No. 97-2000-CFX Title: American Manufacturers Mutual Insurance Company, et al., Petitioners
v.
Delores Scott Sullivan, et al.

Docketed:
June 11, 1998 Court: United States Court of Appeals for the Third Circuit

Entry	Date	Proceedings and Orders
	Jun 11 1998	Petition for writ of certiorari filed. (Response due July 11, 1998)
	Jul 10 1998	Motion of National Association of Waterfront Employers, et al. for leave to file a brief as amici curiae filed.
	Jul 13 1998	Waiver of right of respondents Pennsylvania Secretary of Labor, et al to respond filed. VIDED.
	Jul 13 1998	Brief amici curiae of American Insurance Association, et al. filed.
	Jul 13 1998	LODGING consisting of one copy of a letter from Timothy Wisecarver to Richard Himler (7/1/98) submitted by counsel for insurance amici.
	Jul 13 1998	Brief of respondents Delores Sullivan, et al. in opposition filed. VIDED.
	Aug 25 1998	Reply brief of petitioners American Manufacturers Mutual Insurance Company, et al. filed.
	Aug 26 1998	DISTRIBUTED. September 28, 1998
	Sep 29 1998	Motion of National Association of Waterfront Employers, et al. for leave to file a brief as amici curiae GRANTED.
	Sep 29 1998	Petition GRANTED. The brief of petitioners is to be filed with the Clerk and served upon opposing counsel on or before 3 p.m., Tuesday, November 10, 1998. The brief of respondents is to be filed with the Clerk and served upon opposing counsel on or before 3 p.m., Tuesday, December 8, 1998. A reply brief, if any, is to be filed with the Clerk and served upon opposing counsel on or before 3 p.m., Tuesday, December 29, 1998. Rule 29.2 does not apply. SET FOR ARGUMENT January 19, 1999. **********
	Oct 22 1998	* Blanket consent from petitioners and respondents for all amici received.
	Nov 9 1998	Brief amici curiae of American Insurance Association, et al. filed.
	Nov 9 1998	Brief amici curiae of National Association of Waterfront Employers, et al. filed.
	Nov 10 1998	Brief amicus curiae of Washington Legal Foundation filed.
	Nov 10 1998	Joint appendix filed.
	Nov 10 1998	Brief of petitioners American Manufacturers Mutual Insurance Company, et al. filed.
	Nov 10 1998	Brief of respondent Philadelphia School District filed.
	Nov 10 1998	Brief amicus curiae of United States filed.
	Nov 23 1998	CIRCULATED.
	Dec 7 1998	Motion of Solicitor General for leave to participate in oral argument as amicus curiae and for divided argument

No. 97-2000-CFX

Entry	Date	Proceedings and Orders
		filed.
	Dec 7 1998	Brief amici curiae of Association of Retired Persons, et al. filed.
	Dec 7 1998	Record filed.
	Dec 8 1998	Brief amici curiae of Pennsylvania Trial Lawyers Association, et al. filed.
	Dec 8 1998	Brief of respondents Delores Sullivan, et al. filed.
	Dec 8 1998	Brief amicus curiae of Pennsylvania Federation of Injured Workers filed.
	Dec 8 1998	Brief amicus curiae of Carl Krescholleck filed.
	Dec 14 1998	Motion of Solicitor General for leave to participate in oral argument as amicus curiae and for divided argument GRANTED.
	Dec 29 1998	Reply brief of petitioners American Manufacturers Mutual Insurance Company, et al. filed.
	Dec 29 1998	Reply brief of respondent Philadelphia School District filed.
	Jan 19 1999	ARGUED.

Supreme Court, U.S.
FILED
JUN 11 1998
OFFICE OF THE CLERK

No. 97-2000

In the Supreme Court of the United States

OCTOBER TERM, 1997

AMERICAN MANUFACTURERS MUTUAL INSURANCE COMPANY, ET AL., PETITIONERS

v.

DELORES SCOTT SULLIVAN, ET AL., RESPONDENTS

Petition for a Writ of Certiorari to the United States Court of Appeals for the Third Circuit

PETITION FOR A WRIT OF CERTIORARI

ROBERT MCL. BOOTE
BURT M. RUBLIN
Ballard Spahr Andrews & Ingersoll, LLP
1735 Market Street
Philadelphia, PA 19103
(215) 665-8500

Counsel for All Petitioners Except Donegal Mut. Ins. Co.

ROBERT E. KELLY, JR.
Duane, Morris, Hecksher LLP
305 N. Front Street
Harrisburg, PA 17108
(717) 237-5500

Counsel for Donegal Mut. Ins. Co.

MICHAEL W. MCCONNELL
Counsel of Record
ALAN E. UNTEREINER
STEFFEN N. JOHNSON
SHARON M. SWINGLE
Mayer, Brown & Platt
190 South La Salle Street
Chicago, IL 60603
(312) 782-0600

Counsel for All Petitioners

QUESTIONS PRESENTED

Under Pennsylvania's Workers' Compensation Act, 77 Pa. Stat. Ann. § 531(5) and (6), workers' compensation insurers are permitted to withhold payments to health care providers during a utilization review to determine whether medical treatment was reasonable and necessary. The questions presented are:

1. Whether private companies providing workers' compensation insurance to private employers become "state actors" for purposes of the Due Process Clause when they elect to use a state-authorized utilization review procedure.

2. Whether the Due Process Clause requires workers' compensation insurers to pay disputed medical bills prior to a determination that the medical treatment was reasonable and necessary.

RULE 14.1(b) AND 29.6 STATEMENT

Pursuant to Rule 14.1(b), petitioners state that in addition to American Manufacturers Mutual Insurance Company, petitioners here (also defendants in the court below) include Commercial Union Insurance Company, Continental Casualty Company, Donegal Mutual Insurance Company, Hartford Fire Insurance Company (misidentified in the Third Circuit caption as "Hartford Mutual Insurance Company"), Insurance Company of North America (misidentified in the Third Circuit caption as "CIGNA Corporation"), United States Fidelity and Guaranty Company (misidentified in the Third Circuit caption as "USF&G Insurance Company"), and Zurich Insurance Company (misidentified in the Third Circuit caption as "Zurich American Insurance Company").* Defendants below also include the School District of Philadelphia, the Pennsylvania Secretary of Labor and Industry, the Director of the Pennsylvania Bureau of Workers' Compensation, the Pennsylvania Insurance Commissioner, the Pennsylvania Treasurer, and the Director of the State Workers' Insurance Fund.

In addition to Delores Scott Sullivan, the individual plaintiffs in this putative class action include William Battle, Louis Baumgartner, Anthony Cancila, Christopher Costello, William C. Dillon, by his guardian and next friend Pauline Dillon, Terrence Ervine, Lisa Lex, Charles Matthews, and Susan Hansen. The organizational plaintiffs are the Philadelphia Area Project on Occupational Safety and Health and the Philadelphia Federation of Teachers.

Pursuant to Rule 29.6, petitioners state the following:

American Manufacturers Mutual Insurance Company has no parent companies or nonwholly owned subsidiaries.

The parent companies of Commercial Union Insurance Company ("Commercial Union") are Commercial Union Corporation, Commercial Union Assurance Company plc (UK), and CGU plc (UK). Commercial Union has no nonwholly owned subsidiaries.

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* The parties stipulated below to a substitution of Insurance Company of North America for CIGNA Corporation.

Continental Casualty Company has two parent companies — CNA Financial Corporation and Loews Corporation — and fifteen nonwholly owned subsidiaries: Omega Aseguradora de Riesgo de Trabajo, North American Crop Underwriters, Inc., RVI Guaranty Company Ltd., AMS Services, Inc., The Entertainment Coalition, Home Financial Network, CNA Surety Corporation, HealthPro Solutions, L.L.C., La Salle Re Holdings Limited, La Salle Re Limited, Insurance Reference Systems, Inc., Alliance for Productive Technology, Inc., Insurance News Network, L.L.C., Insurance Information Exchange, L.L.C., and InsWeb Corporation.

Donegal Mutual Insurance Company has no parent companies and one nonwholly owed subsidiary: Donegal Group, Inc.

Hartford Fire Insurance Company's parent companies are Nutmeg Insurance Company and The Hartford Financial Services Group, Inc., and its nonwholly owned subsidiaries are Hartford Life, Inc., CCS Commercial L.L.C., Hartford Calma Company, International Corporate Marketing Group, Inc., American Mutual Life Insurance Company, Hartford Life Insurance Company of Canada, Adapt, Inc., and Trumbull Marketing Resources, L.L.C.

The parent companies of Insurance Company of North America are INA Holdings, INA Financial Corporation, INA Corporation, CIGNA Holdings, Inc., and CIGNA Corporation. Rain and Hail Insurance Service Incorporated is a nonwholly owned subsidiary of Insurance Company of North America.

United States Fidelity and Guaranty Company has two parent companies — USF&G Corporation and The St. Paul Companies, Inc. — and the following nonwholly owned subsidiaries: Afianzandoro Insurgentes Serfin, S.A., Georgeson International, Inc., FGA Corporation, Premium Travel Services, Inc., Castle Pines Village Realty, Inc., and Ashley Palmer, Ltd.

Zurich Insurance Company has no parent companies or nonwholly owned subsidiaries.

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S. ECCLESTON & C. YEAGER, WORKERS COMPENSATION RESEARCH INSTITUTE, MANAGED CARE AND MEDICAL COST CONTAINMENT IN WORKERS' COMPENSATION, A NATIONAL INVENTORY, 1997-1998 (1997) 24, 28

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E. Hirshfeld & G. Thomason, *Medical Necessity Determinations: The Need for a New Legal Structure*, 6 HEALTH MATRIX 3 (1996) 28
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A. Walsh, *The Legal Attack on Cost Containment Mechanisms: The Expansion of Liability for Physicians and Managed Care Organizations*, 31 J. MARSHALL L. REV. 207 (1997) 28

PETITION FOR A WRIT OF CERTIORARI

Petitioners, eight private workers' compensation insurance companies, respectfully ask this Court to issue a writ of certiorari to review the judgment of the United States Court of Appeals for the Third Circuit in this case.

OPINIONS BELOW

The opinion of the court of appeals (App., *infra*, 1a-40a) is reported at 139 F.3d 158. The opinion of the district court dismissing the claims against the private insurers for lack of state action (App., *infra*, 41a-61a) is reported at 913 F. Supp. 895. The district court's subsequent opinion dismissing the complaint and holding that the Pennsylvania statute does not violate procedural due process (App., *infra*, 62a-82a) is unreported.

JURISDICTION

The judgment of the court of appeals was entered on March 13, 1998. This Court's jurisdiction is invoked under 28 U.S.C. § 1254(1).

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

The Fourteenth Amendment to the United States Constitution provides in relevant part that "[n]o State shall * * * deprive any person of life, liberty, or property, without due process of law." The pertinent provisions of the Pennsylvania Workers' Compensation Act (77 Pa. Stat. Ann. § 1 *et seq.*) and relevant regulations are set forth at App., *infra*, 83a-103a.

STATEMENT

A. ***Pennsylvania's Workers' Compensation Statute And Recent Cost-Containment Initiatives.*** Workers' compensation is a system under which employers are obligated to pay for certain medical care for employees who sustain work-related injuries or contract occupational diseases, as well as to pay specific sums as partial replacement of wages, without regard to fault. App., *infra*, 13a-14a. It is a substitute for the prior system of compensation under the common law of tort. See *Blake* v. *Wilson*, 112 A. 126, 128 (Pa. 1920). The Pennsylvania workers' compensation system, involved here, is typical.

Like most States, Pennsylvania makes workers' compensation coverage both mandatory and "exclusive * * * of any and all other liability." 77 Pa. Stat. Ann. § 481(a). The law dispenses with the prior cumbersome and expensive court remedy in tort and replaces it with an administrative procedure aimed at facilitating the prompt resolution of disputes between employees and employers (or their insurers). The vast majority of claims are resolved through voluntary agreement. See D. BALLANTYNE & C. TELLES, WORKERS' COMPENSATION IN PENNSYLVANIA, at xix (1991). Disputes are adjudicated by administrative law judges ("ALJs"), with a right of appeal to the Workers' Compensation Appeal Board ("Board") and then to the Pennsylvania courts. The Bureau of Workers' Compensation ("Bureau"), a part of the Department of Labor and Industry, administers the system and enforces compliance with the workers' compensation laws.

To ensure that employers can meet their financial obligations, the statute requires them to "obtain insurance — either through a private insurance carrier or through the State Workmen's Insurance Fund ('SWIF') — or to self-insure." App., *infra*, 3a. If the employer contracts with a private insurer for coverage, the insurer "assume[s] the employer's liability" to pay workers' compensation benefits. 77 Pa. Stat. Ann. § 501(a)(1). Insurers are not required to sell workers' compensation insurance and are free to decide which employers to underwrite. All features of workers' compensation insurance coverage that are not dictated by law are determined by contract. "[N]o aspect of the workers' compensation system is financed with public tax dollars." D. BALLANTYNE & C. TELLES, *supra*, at 15.[1]

This case involves the procedures for resolution of disputes over reimbursement for medical care. The law requires payment only for "reasonable" and "necessary" medical services. 77 Pa. Stat. Ann. § 531(1), (5). However, it includes within the definition of "medical services" not only "services rendered by

[1] If a workers' compensation insurer in Pennsylvania becomes insolvent, its obligations are assumed by the Workers' Compensation Security Fund, 77 Pa. Stat. Ann. § 1053, but that fund is underwritten by the insurers themselves, *id.* § 1055. See also App., *infra*, 14a n.18.

physicians" but also the services of "any * * * physical therapist, psychologist, [or] chiropractor." 77 Pa. Stat. Ann. §§ 29 (defining "health care provider"), 531(1)(i), 531(3)(iii). Treatment by non-physician providers generates the vast majority of disputes over the reasonableness and necessity of care. The individual respondents in this case, for example, include one worker whose twice-weekly chiropractic sessions were deemed unreasonable and unnecessary after two years of treatment (C.A. App. A97); one who was undergoing "aquatic therapy" (*id.* at A100); one who was still receiving chiropractic services and physical therapy more than fifteen years after his injury, and nearly twelve years after he had returned to work (and who was running his own business) (*id.* at A105-06); and one receiving psychological and biofeedback therapy (*id.* at A112). The Third Circuit stated that procedural safeguards are "particularly" pertinent to recipients "of unorthodox, naturopathic, or non-traditional" treatments "such as * * * acupuncture or chiropractic manipulation." App., *infra*, 31a.

Prior to 1993, insurers had no effective means to limit payments to "reasonable" and "necessary" care. The "spiraling costs of medical treatment for work-related injuries" (App., *infra*, 3a) became a "significant problem[] in the Pennsylvania system." D. BALLANTYNE & C. TELLES, *supra*, at 30. In an effort to control these costs, in 1993 the Pennsylvania legislature passed Act 44, creating "a utilization review process under which the reasonableness and/or necessity of an employee's [current, prospective, or past] medical treatment could be reviewed." App., *infra*, 3a. Among other things, the Act provided: "All payments to providers for treatment provided pursuant to this act shall be made within thirty (30) days of receipt of such bills and records unless the employer or insurer disputes the reasonableness or necessity of the treatment provided pursuant to paragraph (6)." 77 Pa. Stat. Ann. § 531(5). Under this provision, insurers were permitted — though not required — to withhold payments for disputed medical bills until after utilization review.[2] This was

[2] The court of appeals called this delay in payment a "supersedeas" (App., *infra*, 2a, 13a), but that term does not appear in Section 531(5), as the district court noted. App., *infra*, 41a (stating that "plaintiffs' counsel characterize[d]" the statute "as an 'automatic supersedeas'").

important because the law prohibits insurers and employers from recouping any payments made to health care providers or employees, even if the treatment is later determined to be unreasonable or unnecessary. App., *infra*, 27a; see *Moats* v. *Workmen's Compensation Appeal Bd.*, 588 A.2d 116, 118 (Pa. Commw. Ct. 1991). Insurers and self-insured employers are entitled to reimbursement for excessive payments from a special fund, but the fund is financed entirely from assessments levied on the insurers and self-insured employers themselves. 77 Pa. Stat. Ann. § 999. As a result, insurers and self-insured employers as a group ultimately bear all the costs of unnecessary or unreasonable medical treatment once payments have been made.

Utilization review must be initiated by an insurer (or employer) "within 30 days of the receipt of the bill and medical report for the treatment at issue." 34 Pa. Code § 127.404(b). It is triggered by the filing of a form with the Bureau. The Bureau conducts no substantive review of the form to determine whether utilization review is appropriate. It merely determines whether the form contains the information required and then forwards the form to a private utilization review organization ("URO") selected randomly by the Bureau from a list of approved review organizations. 34 Pa. Code § 127.453. The Bureau also sends a notice to the employee, the employer (or insurer), and the provider, identifying the URO that will conduct the review. *Ibid.* The URO's review must be conducted by a medical professional who is "licensed in the same profession and ha[s] the same or similar specialty as that of the provider of the treatment under review." 77 Pa. Stat. Ann. § 531(6). The URO gives notice to the medical care provider, who must be given an opportunity to discuss treatment decisions. 34 Pa. Code § 127.469. Utilization review applies "generally accepted treatment protocols," *id.* § 127.467, and a presumption that disputed treatment is reasonable and necessary. *Id.* § 127.471(b). The utilization review is "solely based upon the medical records of the treating medical provider and any discussions that the URO has had with th[at] provider" (App., *infra*, 7a); neither the employer nor the employee has any right to provide input directly in this process.

Under the statute, the URO must issue a written decision within thirty days of a request, though in practice this typically

takes about seventy days. The URO's decision may be challenged by filing a petition with an ALJ, who will conduct a hearing at which the employee may submit testimony. App., *infra*, 9a. If the URO determines that the disputed medical service was reasonable and necessary, the insurer must pay the bill immediately with 10% annual interest. 34 Pa. Code § 127.208(e); 77 Pa. Stat. Ann. § 717.1(a). If the URO decides that the medical service was unreasonable or unnecessary, then the insurer need not pay the bill unless that decision is overturned by the ALJ, the Board, or the courts.

Originally, Act 44 permitted reconsideration of the URO's determination through a second utilization review. In 1996, the Pennsylvania legislature eliminated such reconsideration through the passage of Act 57. App., *infra*, 8a-9a.

B. ***Proceedings In The District Court.*** Plaintiffs in this putative class action are ten individuals who were or are employed in Pennsylvania and two organizations that represent Pennsylvania employees. See page ii, *supra* (Rule 14.1(b) statement).[3] The private defendants are American Manufacturers Mutual Insurance Company and seven other workers' compensation insurance companies (petitioners here); the public defendants are various state officials and agencies. See *ibid.* Plaintiffs' complaint requested that the court certify a defendant class of all insurance companies and self-insuring employers that have invoked the Pennsylvania utilization review procedure and withheld reimbursement for medical care during the pendency of that review. C.A. App. A84. They alleged that Act 44's utilization review procedures violate due process and 42 U.S.C. § 1983 because they permit the deprivation of "medical benefits" without "prior notice and opportunity to be heard." C.A. App. A76. They sought declaratory and injunctive relief, restoration of benefits, and compensatory and punitive damages.

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[3] The proposed plaintiff class "consists of more than 40,000 workers' compensation recipients" who "have been, or will be in the future, receiving medical benefits pursuant to the Pennsylvania Worker's Compensation [Act]" and whose benefits have been or will be suspended during utilization review. C.A. App. A79-A80, A84.

The private insurers moved to dismiss on the ground that they are not state actors and thus cannot be sued for violations of the Due Process Clause or for action "under color of state law" within the meaning of 42 U.S.C. § 1983. After limited discovery, the district court granted the private insurers' motion on the state action issue on January 24, 1996. App., *infra*, 41a-61a. The court explained that the government's involvement in the private insurer's decision to invoke utilization review was minimal (*id.* at 59a):

> [T]he decision to cease paying medical benefits is entirely up to the insurer acting independent of any state involvement whatsoever. The state takes no substantive step to promote, support or encourage the decision of the insurer; and after the decision is made, the state takes no action which influences the ultimate substantive determination as to whether benefits are payable or not. The state does not significantly assist private actors when it merely provides a remedy, albeit complete with authorized forms and regulations. The state's acceptance and routing of forms * * * involves acquiescence and not compulsion on the part of the state.

The state officials who remained as defendants subsequently moved to dismiss on the ground that the statute does not violate procedural due process. On November 7, 1996, the district court granted that motion. App., *infra*, 62a-81a. The court concluded that plaintiffs' interest in continued receipt of medical benefits, while "significant" (*id.* at 70a), was less substantial than the interest at stake in *Goldberg* v. *Kelly*, 397 U.S. 254 (1970), because eligibility is "not based on financial need" and "plaintiffs may have access to additional income sources such as wage replacement." App., *infra*, 70a. Moreover, the availability of ALJ review of the URO's decision as well as full retroactive relief, 10% interest, and attorneys' fees to the worker who successfully challenges an adverse decision "lessens the potential harm to the individual employees." *Ibid.*

C. ***Proceedings In The Court Of Appeals.*** A panel of the Third Circuit reversed the district court's rulings on both state action and due process issues. App., *infra*, 1a-40a. In holding that the private insurers are state actors, the court of appeals

emphasized that the workers' compensation system is mandatory in nature, abolishes the common law rights of employers and employees, and provides "the *exclusive* remedy available to an injured worker" in Pennsylvania. *Id.* at 13a-14a. The court also stressed that "[i]n creating and executing this system of entitlements, the Commonwealth has enacted a complex and interwoven regulatory web enlisting the Bureau, the employers, and the insurance companies." *Id.* at 14a. Pennsylvania

> extensively regulates and controls the Workers' Compensation system. Although the insurance companies are private entities, when they act under the construct of the Workers' Compensation system, they are providing public benefits which honor State entitlements. In effect, they become an arm of the State, fulfilling a uniquely governmental obligation under an entirely state-created, self-contained public benefit system.

Id. at 14-15a. The Pennsylvania law thus creates a "relationship" between the State and the insurer which "more than suffices to satisfy the constitutional requisites under the tests — varied though they may be — for state action." *Id.* at 19a.

The court acknowledged that the Fifth Circuit had concluded that private insurers are *not* state actors in the context of a similar dispute in Texas, see *Barnes* v. *Lehman*, 861 F.2d 1383 (1988), but stated "we do not share the Fifth Circuit's view." App., *infra*, 17a. The court also purported to distinguish *Barnes* on the basis of several possible differences in the specifics of Texas law.

Finally, the Third Circuit rejected the insurers' argument that a finding of no state action was dictated by *Blum* v. *Yaretsky*, 457 U.S. 991 (1982), *Rendell-Baker* v. *Kohn*, 457 U.S. 830 (1982), *Flagg Bros.* v. *Brooks*, 436 U.S. 149 (1978), and *Jackson* v. *Metropolitan Edison Co.*, 419 U.S. 345 (1974). Those cases, the court of appeals explained, are distinguishable because they "do not * * * involve a comprehensive statutory scheme similar to that present in this case." App., *infra*, 18a.

Turning to the due process issue, the Third Circuit first held that the notice provided to employees that payments might be withheld from medical providers was constitutionally deficient.

App., *infra*, 21a-25a. (That issue is not in dispute in this petition. See note 12, *infra*.) Next, the court evaluated whether payments for disputed medical services could be withheld pending utilization review. The court characterized this question as whether respondents are entitled to an opportunity to be heard prior to a deprivation. Applying the balancing test of *Mathews* v. *Eldridge*, 424 U.S. 319, 335 (1976), the court held that insurers are required to pay the disputed bills until workers are given "an opportunity and time to submit a personal statement in writing" to the URO "regarding the employee's view of the reasonableness and/or necessity of the disputed medical treatments." App., *infra*, 33a. The court rejected the contention that in applying the *Mathews* test it was required to "consider the conflicting private interest of the insurance companies." *Id.* at 27a.

The Third Circuit acknowledged that Pennsylvania has a legitimate interest in "containing the rising costs of medical care and insurance payments," and observed that "cost containment is the purpose" behind the State's enactment of the law authorizing insurers to withhold payments to medical providers during utilization review. App., *infra*, 29a-30a. "On balance," however, the court explained, "we are not convinced that any governmental interest outweighs the private interest." *Id.* at 30a. The court accordingly struck down the portion of the statute allowing payments to be delayed pending utilization review.

REASONS FOR GRANTING THE PETITION

In conflict with four other federal courts of appeals (but in agreement with two district courts), the Third Circuit held that private companies voluntarily providing workers' compensation insurance to private employers are "state actors" for purposes of the Fourteenth Amendment. That holding effectively empowers judges to substitute their conception of proper risk allocation in the insurance industry for that of state legislatures and regulators and the private actors involved. When evaluating the procedural fairness of acts of state governments, judicial review is essential because the self-interest of the States involved requires review by an independent body. But there is no such justification for judicial intervention when the state governments are engaged in regulating and balancing the interests of *private parties* (such as employers,

workers, medical providers, and insurance companies). In such cases, the courts are simply substituting their own (often uninformed, and politically unaccountable) judgments for those of legislators, state regulators, and the private market. The expansive "state action" doctrine espoused by the court of appeals is thus a species of "*Lochner* in reverse." See *Lochner* v. *New York*, 198 U.S. 45 (1905). If the error of *Lochner* was to think that courts may second-guess legislatures in the fields of social and economic policy in the interest of minimal regulation, the error of the court below is to second-guess legislatures and private markets in the interest of more costly and intrusive regulatory requirements. Either way, this exceeds the bounds of proper judicial authority.

The court of appeals's expansive due process holding also warrants review. The Third Circuit imposed a costly and novel obligation on the insurers — the duty to pay disputed medical bills prior to a determination that the medical treatment is reasonable or necessary — on the theory that delayed payment of bills is tantamount to a governmental "deprivation" of medical treatment without notice and an opportunity to be heard. Because insurers are forbidden to recoup payments wrongfully made to medical providers, this means, in effect, that insurers have no means of limiting payment for past treatments to those medical bills that are for reasonable or necessary medical care. This judicially created payment obligation is inconsistent with the laws of (and established practices of insurers in) every other State, was imposed without a proper evaluation of the competing private interests at stake, and renders utilization review meaningless as a means of medical cost containment. It also conflicts with the decisions of this Court and the lower courts. The Third Circuit's interpretation of the Due Process Clause thus raises a constitutional question of both doctrinal and practical importance.

I. THE THIRD CIRCUIT'S STATE ACTION HOLDING WARRANTS FURTHER REVIEW

A. The Decision Below Conforms To No Coherent Theory Of State Action, And Conflicts With Decisions Of This Court

The decision of a private insurance company to postpone payment of a disputed claim until completion of utilization review has none of the hallmarks of "state action" identified by this

Court's precedents. See *Lugar* v. *Edmondson Oil Co.*, 457 U.S. 922, 939 (1982). Petitioners are private companies that have voluntarily entered into private contracts of insurance with private employers. The decision to withhold payment of disputed medical bills is made entirely by petitioners, with no coercion or encouragement by the State. The postponement of payments requires no assistance from state officials; in this respect it cannot be distinguished from the decision of any private party to withhold contract payments until a dispute is resolved. As one court has explained:

> What is here involved is a contractual (although sanctioned by statute) claim to benefits which the other party to the contract disputes. As such, this interest is indistinguishable from the interest of the recipient of funds in any commercial situation in which periodic payments are terminated pending resolution of the underlying dispute.

Silas v. *Smith*, 361 F. Supp. 1187, 1192 (E.D. Pa. 1973) (three-judge court). To be sure, the underlying workers' compensation liability of the employer, which is the subject of the insurance, is mandated by the State, but that fact does not render the State responsible for the payment, or the insurer an arm of the State. Tort liability is also mandated by the State, but that does not make tort liability insurers state actors.

The Third Circuit's conclusion that petitioners are "state actors" is based on an undigested collection of considerations that do not — singly or together — add up to state action.

First, the court observed that the system is "mandatory" and "exclusive," making workers' compensation payments a "constitutionally protected entitlement," and even a "public benefit." App., *infra*, 14a-15a. Yet the workers' compensation system is more accurately viewed as a mandatory term of the private employment contract between employer and employee, not unlike the minimum wage. The State's mandate runs to the employer, not the insurer (which is under no statutory obligation to provide coverage to the employer). Nor are the payments "public" in the sense of being obligations of the State. See *Dillard* v. *Industrial Comm'n*, 416 U.S. 783, 798 (1974) (workers' compensation funds "are private, not public").[4] The tort system is no less "mandatory" or "exclusive" than workers' compensation, and valid tort claims have an equal claim to be described as "constitutionally protected entitlements," yet no one would say that insurance payments to a tort victim are "public benefits."

Second, the court described the workers' compensation system as "a complex and interwoven regulatory web" (App., *infra*, 14a), a "'system which the government alone administers'" (*id.* at 15a (quoting *Edmonson* v. *Leesville Concrete Co.*, 500 U.S. 614, 622 (1991))). "The Act * * * inextricably entangles the insurance companies in a partnership with the Commonwealth * * * ." App., *infra*, 19a. It is, however, well established that state regulation — even "extensive and detailed" regulation — does not "convert [a private company's] action into that of the State for purposes of the Fourteenth Amendment." *Jackson* v. *Metropolitan Edison Co.*, 419 U.S. 345, 350 (1974).

Finally, the court of appeals relied on the fact that an insurance company (or employer) seeking utilization review must first file a form with the Bureau, which will be disapproved if it fails to include certain required information. According to the court, this means that "the insurers have no power to deprive or terminate such benefits without the permission and participation of the Commonwealth" (App., *infra*, 15a) and "the Commonwealth is intimately involved in any decision by an insurer to * * * suspend medical payments." *Ibid.* The requirement of filing a form, however, is an inconsequential detail in the regulatory scheme. The Bureau's role in processing the form (including forwarding the form, if properly completed, to a URO to conduct the review) is purely ministerial. The Bureau reviews the form only "to ensure that it is properly completed — *i.e.*, that all information required by the form is provided," and not in any way to "address the legitimacy or lack thereof of the request for utilization review." *Id.* at 5a; accord *id.* at 50a, 59a. The State has no involvement

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[4] This distinguishes *West* v. *Atkins*, 487 U.S. 42 (1987), on which the court of appeals relied. App., *infra*, 16a-17a (analogizing workers to prisoners on ground that both are "locked into the system"). In *West*, the private party was engaged to fulfill constitutional obligations *of the State*.

whatsoever in the substance of the decision either to seek utilization review or to withhold payments during that process. In addition, unlike in cases such as *Tulsa Professional Collection Services* v. *Pope*, 485 U.S. 478 (1988), the insurance company does not *need* the assistance of the State before postponing payment. Delay in paying disputed claims is a common insurer practice, permitted under private insurance contracts. The requirement of filing a form is a (modest) *limitation* on the insurer's natural freedom of action; it is not a form of encouragement, assistance, or joint participation by the State.

Under no coherent theory of state action could these slight connections between Pennsylvania and a private workers' compensation insurer lead to the conclusion that the latter "may fairly be said to be a state actor." *Lugar*, 457 U.S. at 937. Unfortunately, the Third Circuit did not think it necessary to offer a theory. Having cited the three factors just discussed, the court simply concluded that this "relationship more than suffices to satisfy the constitutional requisites under the tests — varied though they may be — for state action." App., *infra*, 19a. It then emphasized that its holding is "expressly limit[ed]" to the "unique context" of this case, as if that could substitute for a clear explanation of why the facts of this case fit within established principles of state action doctrine.

In fact, the Third Circuit's decision conflicts with key precedents of this Court, including *Jackson* v. *Metropolitan Edison Co.*, *Blum* v. *Yaretsky*, 457 U.S. 991 (1982), *Rendell-Baker* v. *Kohn*, 457 U.S. 830 (1982), and *Flagg Bros.* v. *Brooks*, 436 U.S. 149 (1978). In *Jackson*, this Court held that the termination of electric service by a privately owned and operated utility corporation did not constitute state action, even though the utility was heavily regulated by the State, enjoyed "at least a partial monopoly in the providing of electrical services within its territory," and acted in terminating services pursuant to authority granted under a state-approved tariff. 419 U.S. at 354, 358. The private utility's "exercise of the choice allowed by state law" does not constitute state action, the Court explained, "where the initiative comes from it and not from the State." *Id.* at 357. The Court rejected the contention that the utility was a state actor because it was "subject to extensive state regulation." *Id.* at 350. "The

mere fact that a business is subject to state regulation," the Court explained, does not make it a state actor, even if "the regulation is extensive and detailed, as in the case of most public utilities." *Ibid.* Accord *Blum*, 457 U.S. at 1011.

In *Blum*, the Court held that the decisions of private (but heavily regulated) nursing homes to discharge or transfer residents who were Medicaid recipients did not qualify as state action. The nursing homes were required by federal law to establish a utilization review committee ("URC") to determine whether the care provided to such residents was medically necessary. 457 U.S. at 994. Once the URC decided that a resident did not need the care being provided, the resident was transferred (without notice or an opportunity to be heard) to a facility with a lower level of care. In holding that there was no state action, the Court focused narrowly on the "specific conduct of which the plaintiff complains" — the decision to transfer or discharge — and concluded that this conduct was not something for which the government was responsible. *Id.* at 1004, 1008, 1010. Moreover, in *Blum*, the Court rejected the argument that there was state action because New York requires nursing homes to "complete patient care assessment forms and file them with state Medicaid officials." *Id.* at 1006-07, 1010. "We cannot say," the Court explained, "that the State, by requiring completion of a form, is responsible for the physician's decision." *Id.* at 1006-07. See also *Rendell-Baker*, 457 U.S. at 838 (decision of extensively regulated, state-funded school for maladjusted high school students to discharge staff not state action); *Flagg Bros.*, 436 U.S. at 157-66 (warehouseman's sale of goods entrusted to him for storage not state action).

For state action purposes, there is no analytical difference between the suspension of insurance payments under the Pennsylvania statute and the termination of electric service in *Jackson* or the reduction or termination of care through patient discharges or transfers in *Blum*. The Pennsylvania statute does nothing more than permit private parties to withhold payments to health care providers during utilization review (a process conducted not by state officials but by medical professionals employed by private organizations). The insurer's filing of a form with the State, and

the State's forwarding a properly completed form to a URO, are purely formal steps in the process.[5]

The Third Circuit sought to distinguish *Jackson*, *Blum*, *Rendell-Baker*, and *Flagg Bros.*, on the ground that those cases "do not * * * involve a comprehensive statutory scheme similar to that present in this case." App., *infra*, 18a. But that rationale rests on a false premise and is at odds with the essential holdings of *Jackson* and *Blum*. Both the public utility regulation in *Jackson* and the Medicaid regulation in *Blum* were as extensive as, if not more so than, insurer regulation in Pennsylvania. For example, insurers, unlike public utilities, are not required by the State to provide universal service. The crux of *Jackson* and *Blum* is their holding that extensive regulation — whatever its precise nature — does not transform private enterprises into state actors. Indeed, where state legislators have crafted a comprehensive regulatory scheme, there is rarely either need or justification for judicial second-guessing of particular components of that scheme.

B. The Question Presented Is The Subject Of Persistent Conflicts Among The Lower Courts

The Third Circuit's decision, though consistent with several district court cases, is in square conflict with decisions of four courts of appeals and the state courts of Pennsylvania: *Barnes* v. *Lehman*, 861 F.2d 1383 (5th Cir. 1988); *Stanescu* v. *Aetna Life & Casualty Ins. Co.*, 1996 U.S. App. LEXIS 20834 (2d Cir. Aug. 16, 1996), cert. denied, 117 S. Ct. 1697 (1997); *Grenz* v. *EBI/Orion Group, Inc.*, 1992 WL 158158 (9th Cir. July 9, 1992); *Fleming* v. *Workers' Compensation Comm'n*, 1996 U.S. App. LEXIS 3858 (4th Cir. Mar. 5, 1996) (per curiam), aff'g 878 F. Supp. 852 (E.D. Va. 1995); *Henderson* v. *Workmen's Compensation Appeal Bd.*, 452 A.2d 277, 278-80 (Pa. Commw. Ct. 1982). The Eleventh Circuit has identified the issue but not yet

[5] The courts of appeals have uniformly held that ministerial actions by the State are insufficient to give rise to state action. See, *e.g.*, *Gaskell* v. *Weir*, 10 F.3d 626, 628 (9th Cir. 1993) (upholding sanctions imposed for "patently frivolous" argument that court clerk's "ministerial role" in "accepting and filing * * * settlement documents" gives rise to state action).

resolved it. *Cryder* v. *Oxendine*, 24 F.3d 175, 177 (11th Cir. 1994).[6]

The Fifth Circuit decision, *Barnes* v. *Lehman*, involved a worker whose temporary disability benefits under the Texas workers' compensation scheme were terminated by an insurance company on the basis of the treating physician's opinion that the worker was able to return to work. 861 F.2d at 1384-85. The worker sued the insurer, alleging that suspending his weekly disability payments without first affording him an opportunity to be heard violated due process. *Id.* at 1387. The district court dismissed the complaint on the ground that there was no state action. In unanimously affirming, the Fifth Circuit flatly rejected the argument adopted by the Third Circuit in this case: that an insurance company invokes the aid of state officials by "filing the forms incident to ceasing payments." *Ibid.* Citing *Blum*, the Fifth Circuit explained: "Regulations that dictate procedures, forms, or even penalties without dictating the challenged action do not convert private action into state action." *Ibid.* Because "[t]he decision to adopt [the physician's] opinion as final and to cease Barnes's benefits was a decision initiated and carried out by the insurer and not the state," the insurer cannot fairly be said to be a state actor. *Ibid.*

[6] The state action issue arises with regularity because state workers' compensation laws authorize insurers (or employers) unilaterally to suspend payments in a variety of circumstances. For example, some States permit suspension where an employee returns to regular employment or his attending physician releases him to do so. See, *e.g.*, Colo. Rev. Stat. § 8-42-105(3); Mont. Code Ann. §§ 39-71-701, 39-71-712; Or. Rev. Stat. § 656.268(3). Many States authorize suspension of payments when an employee refuses to submit to reasonable medical examination. See, *e.g.*, Ariz. Rev. Stat. § 23-1026C; Colo. Rev. Stat. § 8-43-404(3); Conn. Gen. Stat. § 31-294f(a); Iowa Code § 85.39; Kan. Stat. Ann. § 44-518, § 45; N.H. Rev. Stat. Ann. § 281-A:39; R.I. Gen. Laws § 28-33-38; Wyo. Stat. Ann. § 27-14-609(c). Other States authorize suspension where the employee declines to attend either vocational rehabilitation or counseling, *e.g.*, Colo. Rev. Stat. § 8-43-404(3); Mass. Gen. Laws ch. 152 § 45, or to accept suitable employment, see, *e.g.*, Ga. Code Ann. § 34-9-240(b)(2); Iowa Code § 85.33; N.C. Gen. Stat. § 97-32.

The court below acknowledged the conflict with *Barnes*, but declared that "we do not share the Fifth Circuit's view." App., *infra*, 17a. In addition to rejecting the Fifth Circuit's reasoning, the Third Circuit sought to distinguish *Barnes* on several grounds:

> Clearly * * * the statutory provision permitting the termination of benefits in *Barnes* and the supersedeas provisions at issue here vary significantly. In *Barnes*, for instance, the insurance company was not compelled to resume the employee's benefits even after a State officer reviewing the case [so] recommended * * * . Thus, the employee was left with a cause of action under state law only. In addition, it is unclear whether employers and/or employees can opt-out of Texas' * * * scheme. In Pennsylvania * * * they cannot. Moreover, and perhaps most importantly, it is not clear that under Texas law the State involvement was required *prior* to the termination of benefits.

App., *infra*, 17a-18a (citation omitted). These distinctions are either based on a misunderstanding of Texas law or irrelevant to the state action issue. The Third Circuit's suggestion that an insurer need not comply with a state officer's recommendation refers to Texas' procedure for a meeting with a pre-hearing officer "to attempt to adjust and settle the claim amicably * * * ." Tex. Civ. Stat. Ann. art. 8307, § 10(b) (1987). But if the parties failed to agree, the Board would make a final decision, which *was* enforceable against all parties. Thus, the Third Circuit was simply wrong to suggest that the Texas system was merely advisory or that the worker "was left with a cause of action under state law only." App., *infra*, 18a.

As for the Third Circuit's reference to several features of the Texas system that were "unclear" — the right of employers and employees to opt out, and the timing of the State's involvement — those distinctions are simply irrelevant to the state action inquiry. It makes no difference whether an insurer is required to file a form before suspending benefits (as in Pennsylvania) or after (as in Texas).[7] Nor does it matter whether employers and employees

[7] Under the Texas scheme at issue in *Barnes*, an insurer that suspended payment of disputed benefits was required to file a statement of grounds for suspension with the Board within ten days. Tex. Civ. Stat. Ann. art. 8306, § 18a(b) (1987); see also Tex. Civ. Stat. Ann. art. 8307, § 11 (1987) (insurer required to give the Board "the name, number, and style of the claim, the amount paid thereon, and the reason for such suspension or stopping"). If the insurer failed to file this statement or to state fully the reasons for suspension, it faced a penalty of up to 15% of the compensation and benefit amounts past due. *Ibid.*; 28 Tex. Admin. Code § 53.35(b) (1985).

may opt out of the system.[8] The utility customers in *Jackson* could not obtain electricity from another source, but that did not make the utility a state actor. In any event, the potential to opt out of the system as a whole does not alter the extent of state involvement, or the mandatory nature of state requirements, for those who do *not* opt out. And it has no bearing on the decision of a *private insurance company* — whose participation is voluntary in either case — to suspend payments. The insurer's decision is not attributable to the State merely because the State mandates participation in the system by employers and employees.

The Third Circuit's decision also conflicts with decisions of the Second, Fourth, and Ninth Circuits. The district court in *Fleming* v. *Workers' Compensation Comm'n*, 878 F. Supp. 852 (E.D. Va. 1995), aff'd, 1996 U.S. App. LEXIS 3858 (4th Cir. Mar. 5, 1996), held that a private insurer that suspended payments of workers' compensation benefits, including medical benefits, under the Virginia workers' compensation statute was not a state actor. The district court explained that the insurer "is authorized, but not required, to suspend benefits," and "the ultimate decision whether to suspend benefits rests with the insurer." *Id.* at 860-61. A panel of the Fourth Circuit unanimously affirmed, explaining that "[a]lthough [Virginia] created the underlying statutory and regulatory mechanism challenged in the instant proceeding, it did not compel or direct the suspension of Fleming's benefits." 1996 U.S. App. LEXIS 3858, at *5 (citing *Barnes*).

[8] Both employers and employees did have a right to opt out of the Texas workers' compensation system. See Tex. Civ. Stat. Ann. art. 8308, § 7 (1987) (employers); *id.* art. 8306, § 3a-3b (employees).

Similarly, in *Grenz* v. *EBI/Orion Group, Inc.*, 1992 WL 158158 (July 9, 1992), the Ninth Circuit held that a private insurer that reduced payments for workers' compensation benefits based on a medical review panel's evaluation of the worker did not qualify as a state actor. The Ninth Circuit rejected the argument that "Montana and the insurers are joint participants in the workers' compensation scheme[] because the state mandates workers' compensation insurance, certifies and regulates workers' compensation insurance companies, and provides workers' compensation directly to a significant numbers of workers." *Id.* at **1. In words that apply with equal force to this case, the court of appeals explained that "there is no indication that the *state itself* has anything to do with a medical review panel decision or what the insurer decides to do based on its findings." *Ibid.* (emphasis added). See also *Freier* v. *New York Life Ins. Co.*, 679 F.2d 780, 783 (9th Cir. 1982) (insurer's reduction of workers' compensation benefits held not to be action under color of state law (citing 42 U.S.C. § 1983)).

In *Stanescu* v. *Aetna Life & Casualty Ins. Co.*, 1996 U.S. App. LEXIS 20834 (Aug. 16, 1996), cert denied, 117 S. Ct. 1697 (1997), the Second Circuit affirmed the dismissal of an action brought under 42 U.S.C. § 1983 by an employee whose workers' compensation benefits were suspended by an insurance company. The court held that the private insurer's suspension of benefits did not qualify as action "under color of state law" (which is coextensive with the state-action requirement). 1996 U.S. App. LEXIS 20834, at *3. The Second Circuit rejected the argument that Aetna was a state actor because the Connecticut Workers' Compensation Act provided the "exclusive remedy available" to the plaintiff. *Id.* at *3-*4.[9] See also *Gyadu* v. *Workers' Compensation Comm'n*, 930 F. Supp. 738, 750-51 (D. Conn. 1996) (no state action where insurer temporarily suspends workers' compensation

[9] Although the unanimous opinions of the Second Circuit in *Stanescu*, the Fourth Circuit in *Fleming*, and the Ninth Circuit in *Grenz* are unpublished, other courts (including the district court in this case) have cited and relied upon them in published decisions. See App., *infra*, 56a-57a (citing and discussing *Grenz*); *Fleming*, 878 F. Supp. at 860 (same).

benefits and "[t]here is nothing to indicate that the [State] participated in this decision"), aff'd, 129 F.3d 113 (2d Cir. 1997).

The Third Circuit's decision is also in conflict with the Pennsylvania courts' resolution of the state action issue. In *Henderson* v. *Workmen's Compensation Appeal Bd.*, 452 A.2d 277 (1982), the Pennsylvania Commonwealth Court, which has exclusive jurisdiction over appeals from the Workmen's Compensation Appeal Board (subject to discretionary review by the Pennsylvania Supreme Court), held that a private insurer that suspends payments for workers' compensation benefits does not qualify as a state actor. *Id.* at 278-80. The Commonwealth Court reasoned that the employer and employee have "a private contractual relationship and, if the [Workers' Compensation] Act did not exist, the employer would be free to stop payments if it determined that the employee's disability had ended." *Id.* at 279. The court rejected the argument that a private insurer is a state actor because workers' compensation is "highly regulated" and the statute provides "the exclusive means" for suspending payments. *Ibid.*

Other federal and state courts have similarly concluded that insurers (or employers) are not state actors in the context of state workers' compensation laws. See, *e.g.*, *Koller* v. *Aetna Life Ins. Co.*, 717 F. Supp. 648, 649 (E.D. Wis. 1988) (insurer's refusal to pay for substantial portion of medical care not action "under color of law" within meaning of 42 U.S.C. § 1983, because decision "was a purely private one, notwithstanding that [insurers] are licensed and regulated by the state"); *Masel* v. *Industrial Comm'n*, 541 F. Supp. 342, 345 (N.D. Ill. 1982) (dismissing due process claim brought against insurer that withheld payments for medical care, on ground that insurer did not act "under color of law"); *Martin* v. *Rush's Fabricare Center, Inc.*, 590 So. 2d 707, 709-10 (La. Ct. App. 1991) (insurer's invocation of dispute resolution scheme not state action).[10]

[10] Cf. *Mirabile* v. *State Farm Ins. Co.*, 1994 U.S. Dist. LEXIS 17841, at *4-*15 (E.D. Pa. Dec. 13. 1994) (private insurer that invokes peer review procedure under Pennsylvania Motor Vehicle Financial Responsibility Law to resolve dispute over medical treatments held not to be state actor); *Brownell* v. *State Farm Mutual Ins. Co.*, 757 F. Supp.

The Third Circuit is not, however, alone in concluding that private insurers are state actors in this context. In *Davis* v. *Caldwell*, 53 F.R.D. 373 (N.D. Ga. 1971), a three-judge court held that the Georgia workers' compensation law violated due process by permitting an insurer to cease payments to a worker without a prior hearing. The court reasoned that workers' compensation is a "program of state-supervised benefits" that "carries out" public policy. *Id.* at 377. "It seems clear," the court concluded, "that there is 'state action' here" under 42 U.S.C. § 1983. *Ibid.* In *Baksalary* v. *Smith*, 579 F. Supp. 218, 230-31 (E.D. Pa. 1984), appeal dismissed, 469 U.S. 1146 (1985), another three-judge court held that a private insurer was a state actor when it ceased payments under a prior provision of the Pennsylvania workers' compensation statute. The *Baksalary* court refused to follow the Pennsylvania courts' decision in *Henderson* on the ground that "[d]ecisions by Pennsylvania courts on issues of federal law merit our respectful consideration" but "are not controlling." 579 F. Supp. at 230 & n.19.

In sum, the conflict in the lower courts is both deep and abiding. Only this Court can resolve the disagreement among the circuits.[11]

526, 539-41 (E.D. Pa. 1991) (same). As the *Mirabile* court explained, plaintiff's due process claim "amounts to an attempt to convert an arguable — and temporary — breach of contract by an insurer into a civil rights claim * * * simply because the insurer chose to invoke state statutory procedures to delay payment of medical expenses which plaintiff contends were covered under an automobile insurance policy. * * * [T]he fact that the state regulates automobile insurance contracts to some extent does not give rise to a constitutionally protected right to payment of claims and does not convert insurers * * * into state actors." 1994 U.S. Dist. LEXIS 17841, at *4.

[11] Twice before, this Court has entertained appeals to resolve the state action and due process issues raised when a private workers' compensation insurance company withholds payments on a disputed claim, but both times the case was resolved on other grounds or dismissed for want of jurisdiction. *Dillard* v. *Industrial Comm'n of Virginia*, 416 U.S. 783 (1974); *Baksalary* v. *Smith*, 579 F. Supp. 218 (E.D. Pa. 1984), appeal dismissed, 469 U.S. 1146 (1985).

C. This Court's Review Is Needed To Bring Coherence To This Unsettled Area Of Law

This case offers a valuable opportunity to clarify state action doctrine, which, as the Third Circuit observed, is "one of the most troublesome issues of constitutional law." App., *infra*, 13a. The analytical framework for deciding when the conduct of a private entity "allegedly causing the deprivation of a federal right [is] fairly attributable to the State" is set out in *Lugar* v. *Edmondson Oil Co.*, 457 U.S. 922, 937 (1982):

> *First*, the deprivation must be caused by the exercise of some right or privilege created by the State or by a rule of conduct imposed by the State or by a person for whom the State is responsible. * * * *Second*, the party charged with the deprivation must be a person who may fairly be said to be a state actor.

Ibid. (emphasis added). The first "factor" under *Lugar* serves to exclude cases where the private entity acts in violation of state law. *Id.* at 940. But as one commentator has noted, the first *Lugar* factor is "of little practical importance" because "[i]f a private actor is breaking the law of the jurisdiction when he harms another individual, it is unlikely that the private actor will be the subject of a suit that centers on whether he had state action when he caused the harm." 2 R. ROTUNDA & J. NOWAK, TREATISE ON CONSTITUTIONAL LAW § 16.1(a), at 527 (2d ed. 1992). And, with all due respect, the second *Lugar* factor — whether the private party "may fairly be said to be a state actor" — is tautological.

Not surprisingly, many of the conflicting decisions cited above turn on conflicting interpretations of what the second "prong" of the *Lugar* test means. Compare *Baksalary*, 579 F. Supp. at 227-28, 230-33 (holding that insurers are state actors because they satisfy the second *Lugar* factor), with *Barnes*, 861 F.2d at 1386-87 ("declin[ing] to adopt" the *Baksalary* court's "broad interpretation" of the second *Lugar* factor); *id.* at 1387 (same), and *Grenz*, 1992 WL 158158, at *1 (rejecting argument that insurer and State satisfy second *Lugar* factor), and App., *infra*, 55-59a (suggesting that *Baksalary* relied on incorrect understanding of second *Lugar* factor). In the face of that confusion, the Third Circuit essentially threw up its hands, justifying its conclusion that private insurance

companies are "state actors" by reference to a congeries of seemingly unrelated factors, none of which is sufficient under this Court's precedents to support the conclusion. App., *infra*, 13a-17a. The court offered no analytical structure or theory to explain why any of the factors were relevant, or what might be the limits on its expansive notion of state action, and refused to be pinned down to any particular theory of "state action" that might explain its decision. Only this Court can clarify the *Lugar* test and bring order to this cacophony. See *Lebron* v. *National R.R. Passenger Corp.*, 513 U.S. 374, 378 (1995) ("It is fair to say that 'our cases deciding when private action might be deemed that of the State have not been a model of consistency.'") (quoting *Edmonson* v. *Leesville Concrete Co.*, 500 U.S. 614, 632 (1991) (O'Connor, J., dissenting)).

II. THE LOWER COURT'S DUE PROCESS HOLDING ALSO MERITS REVIEW BY THIS COURT

The Third Circuit held that the Pennsylvania law violates procedural due process because affected workers are not provided with notice and an opportunity to be heard before an insurer or employer withholds payments for disputed medical treatments.[12] That holding, and the analysis underlying it, is inconsistent with *Connecticut* v. *Doehr*, 501 U.S. 1 (1991), and in conflict with decisions of the Ninth and Eleventh Circuits and other federal courts. Because the due process issue, like the state action issue, is important and recurring, this Court should review it as well.

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[12] Petitioners do not challenge the courts of appeals' holding concerning notice. Following the Third Circuit's decision, the Bureau modified the form that it sends to the affected employee when a utilization review is assigned to a URO. That form now provides notice of the employee's right to submit a written statement to the URO and to appeal an adverse URO decision. See Notice of Assignment of Utilization Review Request (Mar. 1998) (attached as Exh. A to Motion of Insurer Defendants/Appellees for Stay of Court of Appeals' Mandate (filed Mar. 31, 1998)).

A. The Third Circuit's Due Process Analysis Is Inconsistent With *Doehr* And The Decisions Of Other Courts

1. *Doehr* involved a Connecticut statute authorizing prejudgment attachment of real estate based solely on the submission of an affidavit to a state court (and without any showing of extraordinary circumstances). The Court ruled that the statute violated due process because it permitted attachment without affording the property owner prior notice and an opportunity for a hearing. Two features of the Court's decision are germane here. *First*, the Court's analysis was substantially informed by a review of "[h]istorical and contemporary practices" concerning prejudgment attachment, including a "survey of state attachment provisions." 501 U.S. at 16-17. The fact that prejudgment attachment "is a remedy unknown at common law" and that "nearly every State requires either a preattachment hearing, a showing of some exigent circumstance, or both, before permitting an attachment to take place," this Court explained, "confirm[s] our view that the Connecticut provision * * * clearly falls short of the demands of due process." *Id.* at 16-18. See also *Honda Motor Co.* v. *Oberg*, 512 U.S. 415, 430 (1994) ("traditional practice provides a touchstone for constitutional analysis" and the State's "abrogation of a well-established common-law protection * * * raises a presumption that its procedures violate the Due Process Clause"); *Burnham* v. *Superior Court*, 495 U.S. 604, 621-22 (1991) (opinion of Scalia, J.); *Schall* v. *Martin*, 467 U.S. 253, 268 (1984).

Second, the Court held that the three-part balancing test of *Mathews* v. *Eldridge*, 424 U.S. 319, 334-35 (1976), must be modified in evaluating due process challenges to "[p]rejudgment remedy statutes" because such statutes "ordinarily apply to *disputes between private parties* rather than between an individual and the government." *Doehr*, 501 U.S. at 10-11 (emphasis added). Because "any burden that increasing procedural safeguards entails primarily affects not the government, but the party seeking control of the other's property," the "relevant inquiry requires * * * , in contrast to *Mathews*, principal attention to the interest of the party seeking the prejudgment remedy, with, nonetheless, due regard for any ancillary interest the government might have" in forgoing additional procedures. *Id.* at 11.

The Third Circuit's decision is inconsistent with both of these teachings of *Doehr*. The court failed to grasp that *Doehr* "adjust[ed] the third prong of the *Mathews* test to include an analysis of a private party's interest in the remedy when a private party as opposed to the government is acting to effect a deprivation." *Shawmut Bank* v. *Costello*, 643 A.2d 194, 199 (R.I. 1994); accord *Connecticut Natural Gas Corp.* v. *Miller*, 684 A.2d 1173, 1178 (Conn. 1996). Insofar as they govern payment of insurance claims, workers' compensation laws, like prejudgment remedy statutes, "ordinarily apply to disputes between private parties rather than between an individual and the government." *Doehr*, 501 U.S. at 10-11. At bottom, the private insurer's dispute is with a third party beneficiary — the injured employee, or the medical provider — over whether certain medical care, whose reasonableness or necessity the insurer disputes, is covered by the insurer's contract with the employer. Because this case involves a dispute between private parties with conflicting property interests, the Third Circuit was wrong to refuse categorically to "consider the conflicting private interest of the insurance companies." App., *infra*, 27a. That refusal was contrary to *Doehr*.

The Third Circuit's due process analysis also failed to take into account the legislative judgments and traditional practices of the States. Of the forty-one States (and the District of Columbia) whose statutes or regulations specifically address the subject, at least thirty-nine (including Pennsylvania) permit insurers (or employers) to withhold disputed portions of claims during the pendency of utilization review or the resolution of various other disputes regarding the scope of treatment or amount of compensation. See S. ECCLESTON & C. YEAGER, WORKERS COMPENSATION RESEARCH INSTITUTE, MANAGED CARE AND MEDICAL COST CONTAINMENT IN WORKERS' COMPENSATION, A NATIONAL INVENTORY, 1997-1998, at 18-19 (1997); note 6, *supra*.[13] Courts in at least five of the remaining ten States, moreover, have held

[13] The exceptions are North Carolina, where bills over $2,000 need not be paid until after receiving approval by the Industrial Commission, and Oklahoma, where the Oklahoma Workers' Compensation Court makes case-by-case determinations on payment of disputed bills. S. ECCLESTON & C. YEAGER, *supra*, at 219, 232.

that insurers (or employers) may withhold payment without penalty whenever there exists a good faith belief that no payment is due. See, *e.g.*, *Holmes* v. *Alachua County Adult Correctional Inst.*, 404 So. 2d 198 (Fla. Dist. Ct. App. 1981); *Martin* v. *H.B. Zachry Co*, 424 So. 2d 1002 (La. 1982); *Cruz* v. *Liberty Mut. Ins. Co.*, 889 P.2d 1223 (N.M. 1995); *Mayes* v. *Genesco, Inc.*, 510 S.W.2d 882 (Tenn. 1974); *Norfolk/Dep't of Fire* v. *Lassiter*, 324 S.E.2d 656 (Va. 1985); see also 8 A. LARSON, WORKERS' COMPENSATION LAW § 83.41(b)(2) (1997) ("Generally a failure to pay because of a good faith belief that no payment is due will not warrant a penalty.").

At the federal level, the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. § 901 *et seq.*, permits an insurer (or employer) that has voluntarily initiated benefits to an injured worker subsequently to challenge the reasonableness or necessity of medical care. Federal regulations authorize the employer or insurer to suspend payment and request government review of controverted treatment. 20 C.F.R. § 702.233. The insurer or employer is not required to give the worker an opportunity to be heard before suspending payments. *Ibid*. Thus, federal law and the laws of some forty-five States and the District of Columbia permit withholding of payments in the manner implicated here.

The Third Circuit imposed its own untutored intuition about fair procedures in place of the longstanding and considered judgments of the federal government and most of the fifty States. This raises a jurisprudential issue of the highest importance. The recent decisions of this Court — including *Doehr* — have sought to return to the historical roots of the Due Process Clause in the "settled usages and modes of proceeding" of our legal system. *Hurtado* v. *California*, 110 U.S. 516, 528 (1884); *Murray's Lessee* v. *Hoboken Land & Improvement Co.*, 59 U.S. (18 How.) 272, 277 (1856). This insistence that the Due Process balance be informed by the actual "[h]istorical and contemporary practices" of the States (*Doehr*, 501 U.S. at 16) is not mere antiquarianism. Rather, it ensures that the courts' constitutional judgments — which, because of stare decisis, are exceedingly difficult to change — will be based on the solid ground of experience, rather than on the untested ideas, however well-meaning, of federal judges. There is no reason to suppose that the three life-tenured judges on

the Third Circuit panel were in a better position to balance the interests of injured workers, employers, medical providers, insurers, and the public than the consensus of officials elected and appointed by the people for the purpose of making legislative judgments of that sort.

2. The Third Circuit's due process holding conflicts with *Cryder* v. *Oxendine*, 24 F.3d 175 (11th Cir. 1994), and with decisions of other federal and state courts.

a. *Cryder* was a challenge to a provision of the Georgia workers' compensation statute authorizing an insurer to suspend payments after filing with the Board of Workers' Compensation a medical report of the treating physician stating that the worker had fully recovered. The Eleventh Circuit rejected the argument that this provision violated due process because it did not allow the affected worker to be heard prior to the suspension of payments. 24 F.3d at 177-78. The court emphasized the availability of a post-termination hearing before an ALJ at which the worker could be heard, further administrative and judicial review of the ALJ's decision, and "full retroactive relief" as well as "statutory penalties" if the worker ultimately prevails — all features of the Pennsylvania scheme as well. *Ibid.*

Similarly, the Third Circuit's decision is at odds with *Sauceda* v. *Department of Labor & Indus.*, 917 F.2d 1216 (9th Cir. 1990), and other federal and state decisions. In *Sauceda*, the Ninth Circuit held that workers' compensation benefits may be suspended for failure to attend vocational training or mandatory physical examination without first giving the employee an opportunity to be heard. 917 F.2d at 1219. See also *Gyadu* v. *Workers' Compensation Comm'n*, 930 F. Supp. 738, 751 (D. Conn. 1996) (due process not violated by temporary suspension of workers' compensation benefits without prior opportunity to be heard), aff'd, 129 F.3d 113 (2d Cir. 1997); *Masel* v. *Industrial Comm'n*, 541 F. Supp. 342, 345 (N.D. Ill. 1982) (rejecting due process challenge to provision authorizing hearing after employer fails to pay for medical treatment); *Sandoval* v. *Industrial Comm'n*, 559 P.2d 688, 692 (Ariz. Ct. App. 1976) (due process not violated by suspension of disability and medical benefits without prior opportunity to be heard), cert. denied, 432 U.S. 906 (1977); *Department of Labor*

& Indus. v. *Workmen's Compensation Appeal Bd.*, 427 A.2d 1277, 1278 (Pa. Commw. Ct. 1981) (same for suspension of workers' compensation benefits).[14]

Various courts have rejected analogous due process challenges in the context of Medicare or Medicaid. See, *e.g.*, *Himmler* v. *Califano*, 611 F.2d 137, 146 (6th Cir. 1979) (due process satisfied if Medicaid beneficiary is given post-deprivation opportunity to challenge non-payment on grounds of medical nonnecessity); cf. *Gray Panthers* v. *Schweiker*, 652 F.2d 146 (D.C. Cir. 1980) (holding that due process requires explanation of why payment for Medicare treatment was denied, but in no way suggesting that government must continue payment of disputed claims until beneficiary is given opportunity to be heard).

b. The Third Circuit's decision is, however, neither isolated nor aberrational. Four state supreme courts have ruled that it is unconstitutional to suspend payment of workers' compensation benefits before the employee is given an opportunity to be heard. *Beckler* v. *North Dakota Workers' Compensation Bureau*, 418 N.W.2d 770, 774-75 (N. Dak. 1988); *Carr* v. *SAIF Corp.*, 670 P.2d 1037, 1045-46 (Or. 1983) (en banc); *Mitchell* v. *State Workmen's Compensation Comm'r*, 256 S.E.2d 1, 9-10 (W. Va. 1979); *Auxier* v. *Woodward State Hospital-School*, 266 N.W.2d 139, 142-43 (Iowa), cert. denied, 439 U.S. 930 (1978). The opinion below is also consistent with *Baksalary* and with *Davis* v. *Caldwell*, 53 F.R.D. 373 (N.D. Ga. 1971) (three-judge court).

In the analogous Medicaid context, moreover, some courts have reached the same conclusion. *Yaretsky* v. *Blum*, 629 F.2d 817, 821 (2d Cir. 1980), rev'd on other grounds, 457 U.S. 991

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[14] In *Colorado Compensation Ins. Authority* v. *Nofio*, 886 P.2d 714, 719 (1994), the Colorado Supreme Court held that due process was simply *not implicated* where the medical treatment given to an employee covered under the state workers' compensation program was subject to utilization review, notwithstanding that review could result in termination of treatment. Since the workers' compensation program entitled the employee only to reasonably necessary care, the court explained, the employee had no protected interest in receiving a specific type of treatment. *Ibid.*

(1982); *Haymons* v. *Williams*, 795 F. Supp. 1511, 1524 (M.D. Fla. 1992); *Kendall* v. *Brock*, 689 F. Supp. 354, 364-65 (D. Vt. 1987); *Martinez* v. *Bowen*, 655 F. Supp. 95, 98, 102-03 (D.N.M. 1986); *Moffitt* v. *Austin*, 600 F. Supp. 295, 297 (W.D. Ky. 1984). To resolve this pervasive conflict, further review is warranted.

B. The Due Process Holding Threatens To Disrupt Cost Containment Reform

The past decade has seen an explosion in the costs of workers' compensation, and of medical insurance programs more generally. In an attempt to contain these costs, federal and state officials, as well as employers and private insurers, have begun to experiment with various ways of controlling fraud and abuse, and of confining payments to cases of genuine need. Utilization review is one of the most common strategies for cost containment.

Utilization review is the result of research indicating that many physicians provided unnecessary care to patients with no corresponding improvement in patient health. E. Hirshfeld & G. Thomason, *Medical Necessity Determinations: The Need for a New Legal Structure*, 6 HEALTH MATRIX 3, 18-19 (1996). Utilization review attempts to counter the financial incentive created by traditional fee-for-service plans for physicians — or, as in many cases entailing utilization review, chiropractors, physical therapists, acupuncturists, or other providers of unorthodox health care services — to provide services beyond the point of further benefit to the patient. See A. Walsh, *The Legal Attack on Cost Containment Mechanisms: The Expansion of Liability for Physicians and Managed Care Organizations*, 31 J. MARSHALL L. REV. 207, 217 (1997); P. Danzon, *Tort Liability: A Minefield for Managed Care?*, 26 J. LEGAL STUD. 491, 493 (1997) ("Customary care under traditional insurance reflects severe moral hazard and hence overuse of costly services."). Utilization review is of particular importance in the workers' compensation context, where health costs have risen in recent years at a higher average annual rate than overall national medical costs and where patients have no incentive to avoid overuse. S. ECCLESTON & C. YEAGER, *supra*, at 3-4; G. Tracy, *The Importation of Managed Care to the Workers' Compensation System: Time for Re-evaluation and Re-direction*, 9 No. 7 HEALTH LAW. 16, 17 (1997) (overuse of

medical services is a particular problem in workers' compensation context, as providers "shift[] costs from increasingly restrictive group health payers to less restrictive workers' compensation payers" by "providing more intensive and longer duration services"). Unlike standard health insurance, workers' compensation insurance does not require co-payments or include dollar, duration or pre-existing condition limitations. In addition, injured workers who are receiving temporary total disability ("TTD") benefits (which are limited in duration) have a strong incentive to consume additional medical services in order to support a higher award for permanent disability benefits once TTD benefits end.

Yet the holding below renders utilization review almost useless. Under the Third Circuit's decision, payments must be made for disputed treatment before utilization review; once payments are made, they cannot be recouped even if reviewers ultimately conclude that the treatment was unreasonable or unnecessary. See pages 3-4, *supra*.

Due process does not compel such a result. The Third Circuit was misled by its characterization of the issue as a "deprivation" of "medical benefits" (App., *infra*, 27a), when the only real question is the timing of payments to medical providers for services already received. See *Califano*, 611 F.2d at 146. A mere *delay* in payment for medical services is not the same as a *final termination* of medical benefits. A short delay during the utilization review does not require a health care provider to terminate treatment; indeed, the provider has certain legal and ethical duties to continue to provide needed care. And since the insurer is required to make full payment, with 10% interest, to the provider if the utilization review confirms the reasonableness and necessity of the treatment, the provider has every incentive to continue care if it is consistent with standard medical practice. Moreover, the Third Circuit plainly overstated the value of participation by the injured worker in a utilization review process that is conducted by medical experts and based solely on whether the treatment received conforms to standard medical protocols. See *Cryder*, 24 F.3d at 178; *Califano*, 611 F.2d at 147.

Most fundamentally, the court below erred in transforming these issues of legislative and regulatory policy into questions of

constitutional law. The procedures for resolving insurance claim disputes, the allocation of risk of mistake or of fraud and abuse, and the efficacy of cost containment strategies are quintessentially matters for legislative judgment. The Constitution does not impose any one approach to balancing the interests of workers, employers, insurers, and health care providers under state workers' compensation schemes. Federal judges lack the information and expertise to make wise judgments about risk allocation and cost containment strategies; constitutional rulings lack the flexibility needed to adapt to new information and changing circumstances; and the entire system of constitutional law lacks accountability to the people. This Court's wise resolution not to second-guess legislatures on matters of social and economic policy (see *Ferguson* v. *Skrupa*, 372 U.S. 726 (1963); *United States* v. *Carolene Prods. Co.*, 304 U.S. 144 (1938)) does not lose its force simply because the policy issue comes wrapped in "procedure."

The Third Circuit's state action and due process holdings are therefore of a piece. The state action holding transfers authority from legislatures and private contract to the federal courts by defining private companies as state actors, and the due process holding sweeps aside a carefully considered legislative reform (joined by the federal government and at least forty-four States) on the basis of the court's own, unguided opinion about the proper allocation of risk in the context of workers' compensation medical coverage. Unfortunately, the court below is not alone: there is a persistent conflict among state and federal courts on both the state action and the due process issues. This Court's review is imperative to resolve these conflicts and to correct this case of serious judicial overreaching.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted.

ROBERT MCL. BOOTE
BURT M. RUBLIN
Ballard Spahr Andrews & Ingersoll, LLP
1735 Market Street
Philadelphia, PA 19103
(215) 665-8500

Counsel for All Petitioners Except Donegal Mut. Ins. Co.

ROBERT E. KELLY, JR.
Duane, Morris, Hecksher, LLP
305 N. Front Street
Harrisburg, PA 17108
(717) 237-5500

Counsel for Donegal Mut. Ins. Co.

MICHAEL W. MCCONNELL
Counsel of Record
ALAN E. UNTEREINER
STEFFEN N. JOHNSON
SHARON SWINGLE
Mayer, Brown & Platt
190 South La Salle Street
Chicago, IL 60603
(312) 782-0600

Counsel for All Petitioners

JUNE 1998

APPENDICES

APPENDIX A

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

No. 96-2140

DELORES SCOTT SULLIVAN; WILLIAM BATTLE; ANTHONY CANCILA; CHARLES MATTHEWS; CHRISTOPHER COSTELLO; LISA LEX; SUSAN HANSEN, On Their Own Behalf and on Behalf of All Similarly Situated Class Plaintiffs; PHILADELPHIA AREA PROJECT ON OCCUPATIONAL SAFETY AND HEALTH; THE PHILADELPHIA FEDERATION OF TEACHERS, Local 3, AFL-CIO

v.

ROBERT BARNETT, Secretary of Labor and Industry for the Commonwealth of Pennsylvania; FRANK BEAL, Director of the Pennsylvania Bureau of Workers Compensation; CONSTANCE B. FOSTER, Insurance Commissioner for the Commonwealth of Pennsylvania; CATHERINE BAKER KNOLL, Treasurer, Commonwealth of Pennsylvania; JOHN P. O'MALLEY, Director, State Workers' Insurance Fund; AMERICAN MANUFACTURERS MUTUAL INSURANCE COMPANY; CIGNA CORPORATION; CONTINENTAL CASUALTY COMPANY; USF&G INSURANCE COMPANY; ZURICH AMERICAN INSURANCE COMPANY; SCHOOL DISTRICT OF PHILADELPHIA; JOHNNY J. BUTLER, Secretary of Labor and Industry of the Commonwealth of Pennsylvania; RICHARD A. HIMLER, Director of the Pennsylvania Bureau of Workers Compensation; COMMERCIAL UNION INSURANCE COMPANY; DONEGAL MUTUAL INSURANCE COMPANY; HARTFORD INSURANCE COMPANY

Delores Scott Sullivan, William Battle, Louis Baumgartner,* Anthony Cancila, William C. Dillon,* Terrence Ervine,* Charles Matthews, Christopher Costello, Lisa Lex, Susan Hansen, Philadelphia Area Project on Occupational Safety and Health and Philadelphia Federation of Teachers,

Appellants

*pursuant to Rule 12(a) FRAP

On Appeal from the United States District Court
for the Eastern District of Pennsylvania
(D.C. No. 95-cv-00201)

Argued Thursday, September 11, 1997

BEFORE: MANSMANN, NYGAARD and GARTH, *Circuit Judges*

[Opinion filed March 13, 1998]

[Names and Addresses of Counsel omitted]

OPINION OF THE COURT

GARTH, *Circuit Judge:*

The issue we must address on this appeal is whether Pennsylvania's Workers' Compensation Act, 77 Pa. Const. Stat. Ann. § 531(5) and (6) (West Supp. 1997), which provides for the supersedeas of an employee's medical benefits without prior notice or an opportunity to be heard, violates the requisites of procedural due process. We hold that it does. Accordingly, we reverse.

I.

The Pennsylvania Workmen's Compensation Act ("the Act"), 77 Pa. Const. Stat. Ann. § 1 *et seq.*, establishes a compulsory insurance system for employers that provides compensation to employees who sustain work-related injuries and occupational

diseases without regard to an employee's negligence. *See* 77 Pa. Const. Stat. Ann. § 431. To guarantee the payment of an employee's claims, the Act requires employers to obtain insurance — either through a private insurance carrier or through the State Workmen's Insurance Fund ("SWIF") — or to self-insure. *See id.* § 501. When an employer purchases insurance, the insurance company assumes the employer's statutory liabilities. *See id.* §§ 501, 701.

On July 2, 1993, the Pennsylvania legislature amended the Act by enacting Act 44. The purpose of Act 44 was to contain the spiraling costs of medical treatment for work-related injuries. Codified at 77 Pa. Const. Stat. Ann. § 531(5) and (6), Act 44 created a utilization review process under which the reasonableness and/or necessity of an employee's medical treatment could be reviewed. It is these provisions of Act 44 which create the utilization review process and the corresponding supersedeas that are challenged in this action. Utilization review is a process whereby medical providers assess the reasonableness or necessity of current, prospective, or past medical treatment.

Section 531(5) provides the mechanism by which utilization review is invoked. It states in pertinent part:

> The employer or insurer shall make payment and providers shall submit bills and records in accordance with the provisions of this section. All payments to providers for treatment provided pursuant to this act shall be made within thirty (30) days of receipt of such bills and records *unless the employer or insurer disputes the reasonableness or necessity of the treatment provided pursuant to paragraph (6)* . . . .

77 Pa. Const. Stat. Ann. § 531(5) (West 1997) (emphasis added). Hence, an employer or insurer must pay an employee's medical expenses within thirty (30) days of receipt of the medical bills unless the employer or insurer requests utilization review. The decision to invoke utilization review is made independently by the employer or insurer.

A.

Section 531(6) outlines the utilization review process. Section 531(6) provides:

. . . disputes as to reasonableness or necessity of treatment by a health care provider shall be resolved in accordance with the following provisions:

(I) The reasonableness or necessity of all treatment provided by a health care provider under this act may be subject to prospective, concurrent or retrospective utilization review at the request of an employe [sic], employer or insurer. The department shall authorize utilization review organizations to perform utilization review under this act. Utilization review of all treatment rendered by a health care provider shall be performed by a provider licensed in the same profession and having the same or similar specialty as that of the provider of the treatment under review. Organizations not authorized by the department may not engage in such utilization review.

(ii) The utilization review organization shall issue a written report of its findings and conclusions within thirty (30) days of a request.

(iii) The employer or the insurer shall pay the cost of the utilization review.

(iv) If the provider, employer, employe [sic] or insurer disagrees with the finding of the utilization review organization, a petition for review by the department must be filed within thirty (30) days after receipt of the report. The department shall assign the petition to a workers' compensation judge for a hearing or for an informal conference under [77 Pa. Const. Stat. Ann. § 711.1]. The utilization review report shall be part of the record before the workers' compensation judge. The workers' compensation judge shall consider the utilization review report as evidence but shall not be bound by the report.

77 Pa. Const. Stat. Ann. § 531(6).

Thus, utilization review is invoked when an employee, employer, or insurer requests review of specific medical treatment

performed.[1] The party seeking review submits its request to the Bureau of Workers' Compensation ("the Bureau") on a Bureau-prescribed form entitled "Utilization Review: Initial Request" ("Initial Request"). The Bureau reviews the Initial Request to ensure that it is properly completed — i.e., that all information required by the form is provided. *See* 34 Pa. Code § 127.452. The Bureau's review of the Initial Request does not address the legitimacy or lack thereof of the request for utilization review.

If the Initial Request is improperly completed (i.e., does not provide all pertinent information requested by the form), the Bureau denies the request for review and sends the form back to the party. If the Initial Request is completed properly, the request is approved and the party requesting review must serve a copy of the Initial Request upon the remaining interested parties, including the employee, the employer, the insurer, and the health care provider, as appropriate. *See* 34 Pa. Code § 127.452.

At this point, according to the Act's regulations, an employer or insurer with a Bureau-approved request may suspend payment for the medical treatment in question. *See id.* § 127.208.[2] The Act does not require — but permits — suspension of medical benefits.

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[1] An employee is not likely to request utilization review, however, because the invocation of that process can result in the termination of the employee's medical benefits pending such review.

[2] Section 127.208 of the regulations pertinent to the Act provides in part:

> (e) The 30-day period in which payment shall be made to the provider may be tolled only if review of the reasonableness or necessity of the treatment is requested during the 30-day period under the UR provisions . . . . The insurer's right to suspend payment shall continue throughout both the initial review and the reconsideration review of the UR process. The insurer's right to suspend payment shall further continue beyond the UR process to a proceeding before a Workers' Compensation judge, unless there is a UR determination made at reconsideration that the treatment is reasonable or necessary.

34 Pa. Code § 127.208(e) (1996).

In addition, medical providers are not forbidden from continuing to furnish medical services to employees who are subjected to such review, although any such treatment is rendered with the risk that the medical provider ultimately may not be compensated depending upon the resolution of the utilization review. Furthermore, although the employee is given notice that the Initial Request for utilization review has been filed, there is no indication on that form that an employee's medical benefits may be terminated for and during the disputed treatment. Further, the Initial Request does not provide any information or explanation regarding what utilization review entails.

After a request for review is properly filed, the Bureau randomly assigns the case to a Utilization Review Organization ("URO"),[3] and the Bureau again notifies all interested parties that the case has been assigned by sending out a Notice of Assignment form. *See* 34 Pa. Code § 127.453. The Notice of Assignment is a copy of the notice that is sent to the URO, advising the URO that a particular case has been assigned to it. The Notice of Assignment, like the Initial Request, does not inform employees that their medical benefits may be suspended nor does it advise employees of procedures under which their suspension may be protested.

The review process is narrowly tailored to the task of determining whether specific medical treatment is or was reasonable or necessary. Utilization review is conducted by a health care provider[4] who has "the same or similar specialty" as the provider

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[3] "Utilization Review Organizations" are defined as

> those organizations consisting of an impartial physician, surgeon or other health care provider or a panel of such professionals and provides as authorized . . . for the purpose of reviewing the reasonableness and necessity of a health care provider pursuant to section 531(6).

77 Pa. Const. Stat. Ann. § 29 (West 1997).

[4] A "health care provider" is defined as

> any person, corporation, facility or institution licensed or otherwise authorized by the Commonwealth to provide health care services, including, but not limited to, any physician, coordinated care organization, hospital, health care facility, dentist, nurse, optometrist, podiatrist, physical therapist, psychologist, chiropractor or pharmacist and an officer, employe [sic] or agent of such person acting in the course and scope of employment or agency related to health care services.

77 Pa. Const. Stat. Ann. § 29.

who conducted the treatment in question. *See* 77 Pa. Const. Stat. Ann. § 531(6)(i). Accordingly, the reviewer must apply generally accepted treatment protocols to assess the reasonableness or necessity of the questioned treatment. *See* 34 Pa. Code § 127.467. The URO may not request, seek, or obtain independent medical examinations or reports. *See id.* § 127.461. Rather, the review is solely based upon the medical records of the treating medical provider and any discussions that the URO has had with the medical provider concerning the treatment. *See id.* §§ 127.461, 127.469.[5] Lastly, the URO's role is narrowly defined to address exclusively whether the medical treatment in question is reasonable and/or necessary. *See* 34 Pa. Code § 127.470.

The URO must assume that the employee's medical condition is a work-related injury. *See id.* In addition, the URO does not consider whether the employee is still disabled, whether the employee has obtained maximum medical improvement, or whether the fees charged are reasonable. As noted, the URO's exclusive function is to determine the reasonableness or necessity of the prescribed treatment in question.

The URO must issue a report of its findings and conclusions within thirty (30) days of a request.[6] *See* 77 Pa. Const. Stat. Ann.

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[5] The URO must give the treating medical provider an opportunity to discuss the challenged treatment. *See* 34 Pa. Code § 127.469. Neither the statute nor the regulations make any provision for giving the affected employee the same opportunity.

[6] The regulations provide that the URO must complete the review and make a determination within thirty (30) days of receiving the medical

§ 531(6)(ii). The written report must contain findings, conclusions, and citations to generally accepted treatment protocols and medical literature, as appropriate. *See* 34 Pa. Code § 127.472. The URO sends the report to the Bureau which then sends a copy to all interested parties. *See id.* § 127.476. The employer or insurer pays for the initial utilization review. *See* 77 Pa. Const. Stat. Ann. § 531(6)(iii); 34 Pa. Code § 127.477.

B.

Originally, Act 44 permitted reconsideration of the URO's determination if filed within thirty (30) days of the URO's report. *See* 77 Pa. Const. Stat. Ann. § 531(6)(iv). The review on reconsideration mirrored the initial utilization review except that a different URO conducted the review and the Bureau advanced the costs of reconsideration and subsequently billed the losing party. *See* 34 Pa. Code § 127.514. Thus, as with the utilization review, an employee could not testify before a URO concerning the medical treatment on reconsideration. Further, parties were not notified before invoking reconsideration review that they would be billed for the costs of reconsideration review if they lost.

If a party disagreed with the URO's determination on reconsideration, it could file a Petition for Review with the Bureau for *de novo* review before a Workers' Compensation Administrative Law Judge ("ALJ"). If the employee prevailed upon reconsideration, the supersedeas was lifted pending this *de novo* hearing. If the employee lost the reconsideration review, the supersedeas remained in effect. *See id.* § 127.208(f).

Even if the medical services provided were ultimately found to be reasonable and/or necessary, an employee's benefits could be suspended for a considerable length of time pending the initial utilization review, reconsideration, and *de novo* review by an ALJ. While the Act requires the initial utilization review to occur within thirty (30) days of a request, *see* 77 Pa. Const. Stat. Ann. § 531(5)(ii), and reconsideration to be filed within thirty (30) days

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provider's records or within thirty-five (35) days of the date that the URO received the Notice of Assignment, whichever is earlier. *See* 34 Pa. Code § 127.465.

of the URO's determination and decided within 30-35 days thereafter, *see* 34 Pa. Code § 127.508, there is no time-frame specified for adjudication and resolution before the ALJ. Accordingly, employees could have waited months or even years without medical benefits before the reasonableness or necessity of their treatment was resolved.

In 1996, the Act was amended yet again by Act 57. Act 57 streamlined the utilization review process by eliminating the reconsideration process, thereby allowing for faster *de novo* review by an ALJ. Thus, after the initial URO issues its decision, the losing party no longer need seek reconsideration by another URO, but rather may petition for *de novo* review by an ALJ. Under Act 57, if the initial URO rules in favor of the employee, the supersedeas is lifted pending the ALJ's review. If the URO rules against the employee, the supersedeas remains in effect until after the ALJ renders his/her decision. *See id.* § 127.208(e). In all other material respects the provisions of Act 44 remained in effect and are not challenged here.

II.

The Plaintiffs (hereinafter, collectively "Sullivan") in the present § 1983 case are ten individual employees[7] and two organizations representing employees who claim that their medical benefits were suspended without regard to due process: the Philadelphia Area Project on Occupational Safety and Health ("PhilaPOSH"),[8] and the Philadelphia Federation of Teachers

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[7] The Plaintiffs-Appellants are Delores Scott Sullivan, William Battle, Louis Baumgartner, Anthony Cancila, William C. Dillon, Terrence Ervine, Charles Matthews, Christopher Costello, Lisa Lex, and Susan Hansen.

[8] PhilaPOSH is a non-profit organization comprised of over 2000 unions and individual members, representing approximately 300,000 workers in Southeastern Pennsylvania. PhilaPOSH advocates for occupational safety and the rights of injured workers. Plaintiffs alleged that several members of PhilaPOSH had been directly affected by the utilization review procedures challenged in this litigation. *See* Am. Compl. at ¶ 15.

("PFT").[9] Sullivan claims that the amendments to the Act violated the Plaintiffs' constitutional right to due process under the Fourteenth Amendment by permitting their employers and/or insurers to suspend the payment of their workers' compensation medical benefits without prior notice and without affording them an opportunity to be heard.[10] Sullivan filed the amended complaint in this action on May 21, 1996, three months before the amendments in Act 57 rescinding reconsideration review took effect.

The Defendants in this action include various state officials responsible for administering the Act ("the Commonwealth Defendants"),[11] the director of SWIF,[12] the School District of Philadelphia ("the School District"), and several insurance companies.[13]

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[9] In its order dated March 30, 1995, the district court permitted the PFT to intervene as a plaintiff in this action.

[10] The Fourteenth Amendment provides, in pertinent part:

> Section 1. All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and the State wherein they reside. No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

U.S. Const. amend. XIV, § 1.

[11] The state officials are the Secretary of Labor and Industry, Robert Barnett (Appellees name Johnny Butler in this position); Director of Pennsylvania's Bureau of Workers' Compensation, Richard Himler; Insurance Commissioner for the Commonwealth of Pennsylvania, Linda Kaiser; and Treasurer for the Commonwealth, Catherine Baker Knoll.

[12] The Director of SWIF is Ralph Chase.

[13] The insurance companies involved in this action are American Manufacturer's Mutual Insurance Company, Cigna Corporation, Continental Casualty Company, USF&G Insurance Company, and Zurich American Insurance Company.

The insurance company defendants and the School District moved to dismiss the complaint on the grounds that there was no state action involved in suspending Sullivan's medical benefits.[14] Sullivan filed a motion for partial summary judgment on the issue that the insurers and the School District were state actors subject to the constraints of due process. In its opinion and order dated January 24, 1996, the district court ruled that the private insurers were not state actors, but at that time did not decide the state action issue with respect to the School District as the record was incomplete and more discovery was needed. *See Sullivan v. Barnett*, 913 F. Supp. 895 (E.D. Pa. 1996) (hereinafter, "*Sullivan I*").

On May 28, 1996, Sullivan moved for class certification to represent the class of workers who have had or will have their medical benefits suspended under Pennsylvania's utilization review procedures without advance notice or an opportunity to be heard prior to supersedeas of benefits under section 531(5) and (6). *See* Am. Compl. at ¶ 17. Holding that the supersedeas provisions did not offend due process, the district court dismissed the complaint with respect to the Commonwealth Defendants and the School District by orders dated November 7, 1996, *see Sullivan v. Butler*, 1996 WL 654032 (E.D. Pa. Nov. 7, 1996) (hereinafter, "*Sullivan II*"), and December 13, 1996, respectively, without certifying the plaintiff-class. This appeal followed.

We have jurisdiction over this appeal pursuant to 28 U.S.C. § 1291. Our review over the district court's rulings is plenary. See *Weiner v. The Quaker Oats Co.*, 129 F.3d 310, 315 (3d Cir. 1997).

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[14] The insurance company defendants contended that there was no state action with respect to the private decisions that they made. The School District claimed that there was no state action because it did not participate in the decision-making process concerning the invocation of utilization review (and corresponding termination of medical benefits) because it contracted out the payment of its medical liabilities under the Act to a private company which is not a party to the present action. *See* Sch. Dist.'s Mem. in Supp. Mot. to Dismiss at 1-4 (district court docket # 11, 12).

III.

In order for Sullivan to prevail on her claims that the Act does not provide adequate notice nor an opportunity to be heard before her benefits are terminated, the Defendants must be held to be state actors or to be acting under color of state law.[15]

The Commonwealth does not dispute that it is a state actor, and indeed, it would be hard-pressed to do so in light of the fact that it was the Commonwealth that enacted the supersedeas provisions of 77 Pa. Const. Stat. Ann. § 531(5) and (6) which deprive Sullivan of the Workers' Compensation medical benefits to which she is entitled. Nor has SWIF disputed the fact that it is a state actor. *See* Commonwealth Br. at 20 n.12; *see also Rumph v. State Workmen's Ins. Fund*, 964 F. Supp. (E.D. Pa. 1997); *Baksalary v. Smith*, 579 F. Supp. 218, 230 (E.D. Pa. 1984). Further, the School District apparently does not now contest that it is a state actor, as it has not briefed the issue on appeal.[16] The insurers, however, deny that their actions in invoking relief under

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[15] Section 1983 provides a cause of action to individuals who have been deprived of a federal right by a person acting "under color of state law." *See Groman v. Township of Manalapan*, 47 F.3d 628, 633 (3d Cir. 1995). The "under color of state law" requirement of § 1983 and the "state action" element of the Fourteenth Amendment have been interpreted to be "identical in most contexts," *Id.* at 639 n.15; *see also Lugar*, 457 U.S. at 935 n.18. Thus, private parties can be held liable for the alleged due process violations only if "it can be fairly said that the [government] is responsible for the specific conduct of which the plaintiff complains" — here, the suspension of employees' Workers' Compensation medical benefits. *Edmonson v. Leesville Concrete Co.*, 500 U.S. 614, 632, (1991) (O'Connor, J. dissenting) (quoting *Blum* v. *Yaretsky*, 457 U.S. 991, 1004 (1982).

[16] In *Sullivan I*, the district court initially denied the School District's motion to dismiss premised upon the state action issue. *See Sullivan I*, 913 F. Supp. at 905. However, because the district court held that the supersedeas provisions of the Act did not violate procedural due process in *Sullivan II*, the district court did not ultimately find it necessary to reach the state action issue with respect to the School District.

the supersedeas provisions appurtenant to the utilization review process constitute state action. We cannot agree.

State action has been characterized as one of the most troublesome issues of constitutional law. *See* Henry C. Strickland, *The State Action Doctrine and the Rehnquist Court*, 18 Hastings Const. L.Q. 587, 588 (1991). Various cases have led to differing results in factual scenarios that, at least upon first impression, appear to be similar. *Compare Mark v. Borough of Hatboro*, 51 F.3d 1137 (3d Cir. 1995) (concluding that state action existed in context of volunteer fire department), *with Groman v. Township of Manalapan*, 47 F.3d 628 (3d Cir. 1995) (holding that state action did not attach to actions of a volunteer first aid squad). Indeed, the state action inquiry necessarily depends upon the factual contexts in which the controversies arise. *See Lugar v. Edmondson Oil Co.*, 457 U.S. 922, 939 (1982); *Jackson v. Wilmington Parking Auth.*, 365 U.S. 715, 722 (1961) ("Only by sifting through facts and weighing circumstances can the nonobvious involvement of the State in private conduct be attributed its true significance."); *Groman*, 47 F.3d at 639 n.16. To compound the confusion surrounding a state action examination, courts have employed various tests and standards that have been anything but a model of clarity. *See Edmonson v. Leesville Concrete Co.*, 500 U.S. 614, 632 (1991) (O'Connor, J. dissenting) ("Unfortunately, [Supreme Court] cases deciding when private action might be deemed that of the state have not been a model of consistency.").

In order to analyze the state action issue before us, it is critical to place the insurer's role within the Workers' Compensation system in its proper context. The Act provides no-fault compensation to all employees within the Commonwealth for all injuries sustained during the course of one's employment. In exchange for this guarantee of automatic compensation for wage loss and medical costs without regard to proof or fault, employees lost their right to sue their employers in tort. *See Winterberg v. Transportation Ins. Co.*, 72 F.3d 318 (3d Cir. 1995). The Act abolishes an employer's common law defenses and strips an employee of his/her right to sue upon common law causes of

action. Thus, the Workmen's Compensation scheme in Pennsylvania has been held to be the *exclusive* remedy available to an injured worker. *See* 77 Pa. Const. Stat. Ann. § 481(a). [17] *Cf. Travelers Indemnity Co.* v. *DiBartolo*, 131 F.3d 343, 350-51 (3d Cir. 1997) (holding an employer's voluntary purchase of uninsured motorist coverage is a fringe benefit since it is no longer mandated by state law and, thus, is not subject to the exclusivity provision of the Workmen's Compensation Act). The system is mandatory; an employee cannot opt-out of Pennsylvania Workers' Compensation scheme. *See* 77 Pa. Const. Stat. Ann. § 461 (historical notes).

The benefits provided to employees under the Act are a constitutionally protected entitlement. None of the parties disputes this. *See, e.g.*, *Sullivan II* at 4; *see also Baksalary*, 579 F. Supp. at 224-225. The Commonwealth has created this entitlement, and the Commonwealth guarantees that these benefits will be paid to an injured employee.[18]

In creating and executing this system of entitlements, the Commonwealth has enacted a complex and interwoven regulatory web enlisting the Bureau, the employers, and the insurance companies. The Commonwealth extensively regulates and controls the Workers' Compensation system. Although the insurance companies are private entities, when they act under the construct of the Workers' Compensation system, they are providing public

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[17] 77 Pa. Const. Stat. Ann. § 481(a) states, in pertinent part:

> The liability of an employer under this act shall be exclusive and in the place of any and all other liability to such employes [sic] . . . or anyone otherwise entitled to damages in any action at law or otherwise on account of any injury or death . . . .

77 Pa. Const. Stat. Ann. § 481(a) (West 1992).

[18] The Commonwealth guarantees that Workmen's Compensation benefits will be paid by imposing a statutory obligation upon the employer to pay for all work-related injuries of his/her employees. If the employer's insurance company becomes insolvent, however, the Workers' Compensation Security Fund, a fund administered and created by the Commonwealth, assumes the responsibility of paying the benefits to eligible employees. *See* 77 Pa. Const. Stat. Ann. § 1053.

benefits which honor State entitlements. In effect, they become an arm of the State, fulfilling a uniquely governmental obligation under an entirely state-created, self-contained public benefit system. It is a "system which the government alone administers." *Edmonson*, 500 U.S. at 622. Thus, we conclude the insurance companies are a partner or an arm of the State in implementing legislation that administers constitutionally protected entitlements which the Commonwealth has enacted as a matter of policy.

The right to invoke the supersedeas, or to stop payments, is a power that traditionally was held in the hands of the State. When insurance companies invoke the supersedeas (i.e., suspension) of an employee's medical benefits, they compromise an employee's State-created entitlements. The insurers have no power to deprive or terminate such benefits without the permission and participation of the Commonwealth. More importantly, however, the Commonwealth is intimately involved in any decision by an insurer to terminate an employee's constitutionally protected benefits because an insurer cannot suspend medical payments without first obtaining authorization from the Bureau. However this authorization may be characterized, any deprivation that occurs is predicated upon the State's involvement.

There is little difference between the approval required here and that necessary for utilizing a peremptory challenge, *see, e.g.*, *Edmonson*, 500 U.S. at 622, or for employing a nonclaim statute with the assistance of the probate court. *See, e.g.*, *Tulsa Prof'l Collection Serv. v. Pope*, 485 U.S. 478 (1988). "The [Bureau] is intimately involved throughout, and without that involvement" the supersedeas could not operate. *Id.* at 487. Further, the supersedeas lacks the self-executing characteristic that might otherwise render due process concerns irrelevant. To the contrary, the supersedeas provisions at issue are not self-executing, and without the Commonwealth's involvement and approval, the insurance companies would be precluded from suspending medical benefit payments — an aspect of the Workmen's Compensation procedure which they had desired. Accordingly, we hold that the private insurance companies are state actors when they invoke the supersedeas provisions under § 531(5) and (6).

Our decision is consistent with *West v. Atkins*, 487 U.S. 42 (1988). There, the Court held that a private physician under contract with the State of North Carolina to provide medical services to prison inmates acted under color of state law even though the doctor was not directly employed by the State. In *West*, the State was under an affirmative obligation to provide medical care to inmates. The State delegated that responsibility to a part-time contract physician, who assumed the State's obligation. Under these circumstances, the Court held that state action attached to the actions of the private doctor such that the prisoner could maintain a § 1983 cause of action against the doctor.

That the doctor exercised professional judgment and discretion independent of the State was insufficient to relieve him of his constitutional obligations. *See id.* at 52. The Court emphasized that "[i]t is the physician's function within the state system, not the precise terms of his employment, that determines whether his action can fairly be attributed to the State." *Id.* at 55-56. "[T]he dispositive issue concerns *the relationship among the State, the physician, and the prisoner*." *Id.* at 56 (emphasis added).

Similarly, in this case, examining the relationship among the Commonwealth, employer, and the insurance companies, we have concluded that the actions of the insurers constitute state action. The employers are under an affirmative obligation to insure their employees for work-related accidents. This obligation is expressly assumed by the insurance companies when an employer purchases insurance, *see* 77 Pa. Const. Stat. Ann. §§ 501, 701, and is assumed by the Commonwealth if and when an insurer becomes insolvent.[19] Like the constitutional right involved in *West*, the employees under the Act have a constitutionally protected entitlement in receiving their Workers' Compensation medical benefits. In addition, like the prisoner in *West*, the employees cannot elect to go outside the system for medical treatment. Like prisoners, they are locked into the system, and any relief that the employees obtain is strictly through the program which the State has designed. The employees are, in essence, prisoners — albeit

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[19] *See supra* note 17.

beneficiaries — of the Commonwealth's Workers' Compensation system.

Our conclusion is also consistent with the decision of the three-judge district court panel which convened in *Baksalary v. Smith*,[20] 579 F. Supp. 218 (E.D. Pa. 1984), which held that the state action mantle falls upon the insurers. *Baksalary* involved a similar challenge to the Act, held that the insurers acted under color of state law, and accordingly found that there had been a denial of due process in violation of the Fourteenth Amendment from the invocation of section 413, 77 Pa. Const. Stat. Ann. § 774, a similar supersedeas provision.

We are aware that *Baksalary* has been criticized by the Fifth Circuit in *Barnes v. Lehman*, 861 F.2d 1383 (5th Cir. 1988), but we do not share the Fifth Circuit's view. *Barnes* concerned a due process challenge to a provision in Texas' Workers' Compensation Statute that permitted an insurance carrier to terminate medical benefits based upon a medical report. As the *Barnes* decision is predicated upon its interpretation of Texas — as distinct from Pennsylvania — law, it is necessarily inapposite to this case. The *Barnes* court did not explain in detail the procedural involvement of Texas in permitting the insurance company to deny an employee his/her benefits. Clearly, however, the statutory provision permitting the termination of benefits in *Barnes* and the supersedeas provisions at issue here vary significantly. In *Barnes*, for instance, the insurance company was not compelled to resume the employee's benefits even after a State officer reviewing the case recommended that the insurance company reinstate those benefits. *See Barnes*,

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[20] In *Baksalary*, a three-judge panel of the district court comprised of two district court judges and one Court of Appeals judge, convened pursuant to 28 U.S.C. § 2284. In *Baksalary*, employees contested an automatic supersedeas provision under the Act that terminated an employee's benefits without notice or a pre-termination opportunity to be heard. If an employer or insurer filed a petition which alleged that an employee had returned to work at the same or higher rate of pay, or if the petition — accompanied by a physician's affidavit — alleged that the employee had recovered from his/her disability, then the employer or insurer could terminate the employee's Workers' Compensation benefits. *See Baksalary*, 579 F. Supp. at 221.

861 F.2d at 1384. Thus, the employee was left with a cause of action under state law only.

In addition, it is unclear whether employers and/or employees can opt-out of Texas' Workers' Compensation scheme. In Pennsylvania, as we have stated, they cannot. Moreover, and perhaps most importantly, it is not clear that under Texas law that State involvement was required *prior* to the termination of benefits. *See* Tex. Workers' Compensation Law, art. 8307 § 11 (repealed 1989).[21]

Nor do we find other state action authorities to be persuasive in analyzing the context of Pennsylvania's Workmen's Compensation statutory scheme. As we have previously observed, the factual context in which the particular issue arises must be the focus of a state action inquiry. Other cases cited by the insurers such as *Blum v. Yaretsky*, 457 U.S. 991 (1982) (finding no state action when private nursing homes decided to transfer or discharge Medicaid patients without notice or a hearing), *Rendell-Baker v. Kohn*, 457 U.S. 830 (1982) (finding no state action when private school fired employees despite the fact that school was financed from almost exclusively public sources and was extensively regulated by government), *Flagg Brothers v. Brooks*, 436 U.S. 149 (1978) (finding no state action when private warehouseman invoked self-help provisions of New York's Uniform Commercial Code by selling goods entrusted to him), and *Jackson v. Metropolitan Edison Company*, 419 U.S. 345 (1974) (finding no state action when privately owned electric utility terminated a customer's electric service for nonpayment without a hearing), do not, by the very nature of the controversies with which they dealt, involve a comprehensive statutory scheme similar to that present in this case.

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[21] Article 8307, § 11, provides:

> Association suspending payments. When the association suspends or stops payment of compensation, it shall immediately notify the board of that fact, giving the board the name, number and style of the claim, the amount paid thereon, the date of the suspension or stopping of payment thereon, and the reason for such suspension or stopping.

Tex. Workers' Compensation Law, art. 8307, § 11 (repealed 1989).

We therefore conclude that, in the present context of a comprehensive state scheme reflected in the Workers' Compensation statute of Pennsylvania, the private insurers are state actors. The Act mandates compliance by employers, employees, and insurance companies and inextricably entangles the insurance companies in a partnership with the Commonwealth such that they become an integral part of the state in administering the statutory scheme. This relationship more than suffices to satisfy the constitutional requisites under the tests — varied though they may be — for state action. *See Blum*, 457 U.S. at 1004 (state action exists if the State has coerced the action or provided significant encouragement); *Rendell-Baker*, 457 U.S. at 842 (state action exists if there is a symbiotic relationship between the state and the private actor); *Flagg Bros.*, 436 U.S. at 157-59 (state action exists if private actor exercises powers exclusively within the prerogative of the State); *Jackson*, 419 U.S. at 351 (state action exists if a sufficiently close nexus between State and private actor is found); *Mark*, 51 F.3d at 1156 (suggesting courts should employ a totality of circumstances approach to state action inquiries) (Greenberg, J. concurring). We expressly limit our holding here today, however, to the unique context in which the instant supersedeas provisions arise.[22]

IV.

We now address the due process issue that is at the heart of the instant action.

The gravamen of Sullivan's complaint is that the lack of notice afforded under the supersedeas provisions, § 531(5) and (6), of the Act violates the procedural due process guarantees under the Fourteenth Amendment because neither the Initial Request for utilization review nor the Notice of Assignment specifically informs an employee that the insurer or employer can stop paying for the

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[22] In light of our holding that the private insurance companies are state actors and are thus bound by the constraints of due process, we need not address the question as to whether a disparate classification concerning a public insurer, such as SWIF, and the private insurers would violate the Equal Protection Clause of the Fourteenth Amendment.

contested medical treatments pending review.[23] Although employees are notified that their employers or insurers have invoked the utilization review process pursuant to 34 Pa. Code § 127.452, or are notified that the case has been assigned for review to a URO, pursuant to 34 Pa. Code § 127.453(b), Sullivan points out that such notification does not provide any information or explanation concerning what the utilization review process involves. Sullivan also contends that neither notification provides any information about how an employee can contest the underlying allegations that serve the basis for the utilization review. Accordingly, Sullivan argues that such notification is defective because (1) the employee receives no notice that his/her benefits may cease pending review, (2) the employee receives no meaningful notice *prior* to the deprivation, and (3) the employee is not advised of the procedures under which he/she can protest the imminent deprivation.

The Bureau does not dispute that no notice is provided to an employee that his/her medical benefits might be suspended. Rather, the Bureau contends that the decision to discontinue such benefits (i.e., request a supersedeas) is discretionary and is determined solely by the employer or the insurer, not the Bureau. Thus, the Bureau maintains that it does not have information regarding the status of an employees' medical benefits in a utilization review case, and accordingly it does not deny employees of procedural due process by failing to notify them of such information. The Bureau further asserts that this case is not akin to *Goldberg* v. *Kelly*, 397

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[23] Neither party disputes the district court's ruling that Workers' Compensation benefits are a constitutionally protected property interest subject to scrutiny under the Due Process Clause of the Fourteenth Amendment. *See, e.g., Sullivan II* at 4; *see also Baksalary v. Smith*, 579 F. Supp. 218, 224-25 (E.D. Pa. 1984) ("We find that when an individual must forego the use of his [workers'] compensation benefits for as long as one year . . . that individual has undergone the deprivation of a constitutionally protected property interest."). Accordingly, we concentrate upon whether the procedures afforded to employees under the Act comport with the strictures of due process.

U.S. 306, 314 (1970),[24] such that a pre-deprivation hearing is required prior to the suspension of medical benefits. As a result, the Bureau maintains that sufficient process is afforded to employees under the Act.

"The core of due process is the right to notice and a meaningful opportunity to be heard." *LaChance v. Erickson*, ___ U.S. ___, 1998 WL 17107 (1998) at 3; *see also Cleveland Bd. of Educ. v. Loudermill*, 470 U.S. 532, 542 (1985); *Memphis Light, Gas & Water Div. v. Craft*, 436 U.S. 1, 13 (1978); *Fuentes v. Shevin*, 407 U.S. 67, 80 (1972); *Mullane v. Central Hanover Bank & Trust Co.*, 339 U.S. 306, 313 (1950). We will thus address the constitutionality of the pre-deprivation notice the employees receive in this case and their opportunity to be heard, in turn.

A. Notice

"[A]dequate notice detailing the reasons for a proposed termination" of a constitutionally protected liberty or property interest must be afforded to individuals prior to the deprivation. *Goldberg v. Kelly*, 397 U.S. 254, 267-68 (1970). Notice must be "reasonably calculated, under all the circumstances, to apprise interested parties of the pendency of the action and afford them an opportunity to present their objections." *Mullane*, 339 U.S. at 314. The level of notice required before an individual is deprived of a constitutionally protected property interest depends upon the particular benefits at issue. "[D]ue process is flexible and calls for such procedural protections as the particular situation demands." *Morrissey v. Brewer*, 408 U.S. 471, 481 (1972).

In *Memphis Light, Gas & Water Division*, the Supreme Court held that a Memphis utility company did not provide constitutionally sufficient notice to its customers prior to terminating their utilities. Although the utility gave its customers notice that their service could be terminated for nonpayment of their bill, the company failed to inform its patrons of how they could protest or object to charges on their bills. The Court

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[24] In *Goldberg v. Kelly*, the Supreme Court held that a pre-deprivation evidentiary hearing was required prior to the termination of welfare benefits.

concluded that "[n]otice in a case of this kind does not comport with constitutional requirements when it does not advise the customer of the *availability of a procedure for protesting a proposed termination . . . as unjustified.*" 436 U.S. at 14-15 (emphasis added).

In *Goldberg v. Kelly*, the Court considered whether the notice provisions of New York City's welfare termination process comported with due process. As welfare recipients were given seven days advance notice of the impending termination, a letter informing them of the precise questions raised about their continued eligibility and the legal and factual bases for the Department of Social Services' doubts, and a personal conference explaining the same, the Court held that the notice provisions were adequate. *See* 397 U.S. at 268. Similarly, although notice was not directly at issue in *Mathews v. Eldridge*, 424 U.S. 319, 324 (1976), the Court acknowledged that recipients of Social Security disability payments were afforded proper notice which included a letter informing them that their benefits would be terminated prior to the deprivation, a detailed explanation of the reasons for the proposed termination, and the opportunity to submit additional evidence to the agency making the determination prior to the actual deprivation.

Moreover, we held in *Ortiz* v. *Eichler*, 794 F.2d 889 (3d Cir. 1986), that the notice provided by Delaware prior to the termination or denial of Aid to Families with Dependent Children, Food Stamps, and Medicaid benefits was constitutionally deficient because it failed to explain the reasons for the state agency's action and did not contain the agency's specific calculations utilizing an employee's income or financial resources to ascertain his/her eligibility in making its determination. *See id.* at 892, 895.

The Supreme Court of Iowa confronted a similar problem to the one at hand when it considered the notice to which an employee was entitled before his/her Workers' Compensation benefits were terminated. There, the Court held that at a minimum due process required the following:

(1) the contemplated termination,

(2) that the termination of benefits was to occur at a specified time not less than 30 days after notice,

(3) the reason or reasons for the termination,

(4) that the recipient had the opportunity to submit any evidence or documents disputing or contradicting the reasons given for termination, and, if such evidence or documents are submitted, to be advised whether termination is still contemplated,

(5) that the recipient had the right to petition for review.

Auxier v. Woodward State Hospital-School, 266 N.W.2d 139, 142-43 (Iowa 1978).

Informed by established precedent, we hold that in the case of terminating the medical benefits of a workers' compensation employee, at a minimum due process requires that employees receive notice that includes (1) timely notification that their medical benefits might cease prior to the deprivation, (2) an explanation of the reasons for the proposed termination, (3) an opportunity to respond to the accusations alleged, and (4) information advising them of the availability of the procedures that they may utilize to protest the proposed termination.

In the instant case, the notice that an employee receives prior to the termination of his/her medical benefits is constitutionally inadequate. While the employee is notified by the Initial Request that utilization review has been invoked and the reasons upon which the utilization review is based, the Initial Request does not explain that a supersedeas or suspension of one's medical benefits may result nor does it explain what utilization review entails. In addition, it does not inform an employee of any procedures under which the employee can protest the suspension of the medical benefits or contest the merits on which the proposed deprivation is based.

Similarly, the Notice of Assignment does not cure any of the above notice deficiencies. The Notice of Assignment is, in fact, a copy of the notice to the URO informing the URO that a particular case has been assigned. Like the Initial Request, the Notice of Assignment does not notify an employee that his/her medical benefits may be terminated nor does it advise an employee of any procedures under which such termination may be challenged. Further, by the time the Notice of Assignment is received, the

employees' medical benefits may have already been suspended, as the supersedeas can be invoked and thus a suspension of benefits effected upon the proper filing of the utilization review process.

That an employee's medical benefits may be suspended prior to his/her receiving notice of that termination is constitutionally fatal to § 531(5) and (6) under the strictures of the Due Process Clause of the Fourteenth Amendment. *See Carey* v. *Piphus*, 435 U.S. 247, 259 (1978) ("Procedural due process rules are meant to protect persons not from the deprivation, but from the *mistaken* or *unjustified deprivation* of life, liberty, or property.") (emphasis added). At no time prior to the termination is the employee informed of any procedure under which he/she can dispute the supersedeas. As the employee is not informed of the deprivation of his/her medical benefits prior to its taking effect, inadequate notice effectively strips an employee of his/her ability or opportunity to protest or minimize unjustified deprivations.[25]

In *Baksalary* v. *Smith*, 579 F. Supp. 218, 233 (E.D. Pa. 1984), a three-judge panel of the district court held a similar supersedeas provision unconstitutional where it failed to provide notice to the employee until after the benefits had already been terminated. Similarly, we conclude that § 531(5) and (6), the supersedeas provisions pertaining to utilization review of medical benefits, is unconstitutional because it fails to provide employees with adequate pre-termination notice.

Our invalidation of this supersedeas provision of the Act does not thereby annul other provisions of the Act:

> Under Pennsylvania law, separate provisions of a statute are presumed severable, and any particular one will survive a decision voiding another unless it is so interrelated with the void provision or incomplete without it that the legislature could not have intended it to stand alone.

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[25] At oral argument, the Commonwealth conceded that no notice was afforded to the employees whose medical benefits were terminated pursuant to the supersedeas provisions at issue here. In addition, the Commonwealth recognized that providing notice would be "easy" to remedy.

Stoner v. Presbyterian Hosp., 609 F.2d 109, 112 (3d Cir. 1979) (citing 1 Pa. Const. Stat. Ann. § 1925). Thus, under our holding today we do no more than sever the "unless" clause from § 531(5) of the Act. We are thereby left with a statute that reads as follows and that requires employers or insurers to make payments in accordance with the provision of the Act, but that does not give those employers or insurers the discretion or opportunity to invoke the supersedeas of an employee's medical benefits:

> The employer or insurer shall make payment and providers shall submit bills and records in accordance with the provisions of this section. All payments to providers for treatment provided pursuant to this act shall be made within thirty (30) days of receipt of such bills and records.

B. Opportunity to be heard

Due process requires that "an individual be given an opportunity for a hearing *before* he is deprived of any significant property interest." *Boddie v. Connecticut*, 401 U.S. 371, 379 (1971) (emphasis in original). The right to be heard "'must be granted at a meaningful time and in a meaningful manner.'" *Fuentes*, 407 U.S. at 80 (quoting *Armstrong v. Manzo*, 380 U.S. 545, 552 (1965)). While it is undisputed that some sort of hearing is required before an individual is *finally* deprived of a liberty or property interest, due process necessitates some sort of pre-termination opportunity to be heard regarding the basis of the proposed termination. *See Loudermill*, 470 U.S. at 542 ("Even decisions finding no constitutional violation in termination procedures have relied on the existence of some pre-termination opportunity to respond.") "The opportunity to present reasons, either in person or in writing, why proposed action should not be taken is a fundamental due process requirement." *Id.* at 546.

In the case before us, the employees were not given a pre-deprivation opportunity to respond to the proposed termination of their medical benefits. Indeed, as we have discussed above, they were not even given notice of the impending termination. "[The] right to be heard has little reality or worth unless one is informed that the matter is pending and can choose for himself whether to appear or default, acquiesce or contest." *Mullane*, 339 U.S. at 314. So, while the Commonwealth's statutory scheme provides that

employees be given an opportunity for a *post-termination* evidentiary hearing in the form of a *de novo* hearing before an ALJ, we must address what *pre-termination* opportunity to be heard is required to satisfy the constitutional minimum of due process.

In order to determine the extent of the pre-deprivation process, we must consider and balance the following factors:

> First, the private interest that will be affected by the official action. Second, the risk of erroneous deprivation of such interest through the procedures used, and the probable value, if any, of additional or substitute safeguards; and, finally, the government's interest including the function involved and the fiscal and administrative burdens that the additional or substitute procedural requirements would entail.

Mathews v. Eldridge, 424 U.S. 319, 334-35. We will deal with each factor in turn.

(1) Private Interest

The employees' interest is in the uninterrupted payment of their medical benefits pending the final administrative decision on their cases. *Sullivan II* at 5. As the district court acknowledged, this interest is "without a doubt[,] significant." *Id.* Without receiving her medical treatments, a concomitant of having her medical benefits paid to her medical provider, Sullivan alleges that she has endured longer periods of disability, unnecessary pain, and functional restriction. *See* Am. Compl.

Notwithstanding the employees' significant interest, the district court found that these interests were mitigated by several factors. First, the district court noted that, unlike *Goldberg*, termination of one's medical benefits would not deprive an employee of the very means of his/her subsistence. *See Sullivan II* at 5. The district court also concluded that the availability of full remedies mitigates the impact of the supersedeas. *Id.* at 6. For instance, an employee whose medical benefits are reinstated on appeal by an ALJ is entitled to an award of benefits plus ten (10) percent interest. *See* 77 Pa. Const. Stat. Ann. § 717.1(a) (West Supp. 1997). In addition, the prevailing employee may recover the costs of litigating his/her right to medical benefits. *See id.* § 996 (West Supp. 1997).

Additionally, the district court noted — and the Defendants contend — that the Act does not proscribe a medical provider from continuing to treat an employee during the utilization review process. *Sullivan II* at 5 n.4. Indeed, in the amended complaint, some of the Plaintiffs admit to receiving some medical treatments although such treatments were undergoing utilization review. *See, e.g.*, App. A-107 (Louis Baumgartner). Further, there is nothing in the statute that *requires* that an employee's medical benefits be suspended. *See Sullivan II* at 8.

Finally, the Defendants emphasize that this case is unlike *Goldberg*, *Mathews*, and other traditional due process cases because the court must not only weigh the private interest of Sullivan against the governmental interest, but must also consider the conflicting private interest of the insurance companies. The insurers have an interest in not paying for unnecessary and/or unreasonable medical treatment. The Defendants argue this interest is significant because once such treatment is paid it cannot be recouped from employees or their medical providers even if the disputed treatment is found to be unreasonable or unnecessary. *See Moats v. Workmen's Compensation Appeal Bd.*, 588 A.2d 116, 118 (1991) ("[T]he employer may not seek reimbursement from the claimant or be relieved of paying past medical bills."). Accordingly, the district court held that "a full evidentiary hearing prior to a possible temporary suspension of benefits is not an indispensable requisite for the process that is due." *Sullivan II* at 6.

The district court mischaracterized the nature of Sullivan's interest, and in so doing, minimized the severity of the deprivation at issue. The district court apparently viewed the medical benefits as more akin to a pecuniary interest, and not an interest in the relief that the medical treatment provides to injured employees.

The remedies that the Act provides to an employee whose medical benefits are unjustly terminated provide merely superficial redress as they focus upon a monetary interest as distinct from a medical interest in one's well-being. Further, as medical benefits are typically terminated upon invocation of utilization review, the employee does not receive any medical treatment pending review and thus there may be no medical costs to reimburse upon a determination that the medical treatments were, in fact, reasonable

and necessary. Once the supersedeas is invoked, it can take several months before the URO reaches its decision and — before the reconsideration process was rescinded — even longer if reconsideration review was requested.[26] Although a monetary award may compensate an individual for financial losses, a monetary award cannot be deemed an adequate, effective, or appropriate substitute for relieving an employee's disability or pain. Nor can it be a substitute for necessary medical care. Hence, we are persuaded that the employees' private interest in receiving uninterrupted medical benefits is a weighty and significant factor in the pre-termination calculus.

(2) Risk of Erroneous Deprivation

The district court held that the risk of erroneous deprivation in the instant case was slight. The utilization review process considers only medical reports provided directly by the treating physician and related specifically to certain questioned medical procedures and treatments; no independent medical reports are consulted. The reviewer is a physician in the same profession and with the same specialty as the treating physician, and the reviewer is only permitted to apply generally accepted medical protocols to determine whether the questioned treatment is reasonable or necessary. The district court acknowledged — and Defendants argue — that medical reports are unbiased, objective, and trustworthy, and thus, the problems associated with credibility of witnesses are not present such that a pre-deprivation hearing would be helpful. In addition, as reconsideration review has been eliminated by Act 57, an employee can receive a *de novo*

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[26] Although the URO is required to render a decision within thirty (30) days of the receipt of the employee's medical records or sixty (60) days from the date of assignment, in the amended complaint, Sullivan alleges that this time frame is often not adhered to. *See* Am. Compl. ¶ 66. The length of the deprivation here further supports our conclusion that the private interests are significant. *See Mathews*, 424 U.S. at 341 ("the possible length of wrongful deprivation of . . . benefits is an important factor in assessing the impact of official action on the private interests.")(internal quotations and citation omitted); *see, e.g., Baksalary*, 579 F. Supp. at 224 (stating that resolution of case typically took one year or more).

evidentiary hearing before an ALJ more quickly than before.[27] As a result, the district court held that additional safeguards were not necessary to protect an injured employee from being deprived of one's constitutionally protected property interest in receiving medical benefits. We disagree.

Contrary to the district court's conclusions, we believe that the risk of erroneous deprivation is significant and that additional safeguards can meaningfully minimize the risk of wrongful termination of one's medical benefits. As we stated above, employees receive no notice that a supersedeas of their medical benefits will likely result upon the invocation of utilization review. They are given no pre-deprivation opportunity to be heard either in writing or in person; they are not advised of how they can protest or dispute the underlying allegations that their medical treatments are unreasonable or unnecessary. Although the employee's physician must be given an opportunity to discuss the employee's treatment, *see* 34 Pa. Code § 127.469, we are hard-pressed to believe that the portrait of the employee's illness and treatment is complete without a statement or other input from the employee himself.

The district court seems to have equated the teaching of *Mathews* that an evidentiary hearing is not necessarily required prior to the deprivation of a constitutionally protected interest with the notion that no pre-termination process need be afforded at all. We have come to a different conclusion. Due process dictates that employees have some sort of pre-deprivation opportunity to respond before the supersedeas takes effect so as to guard against an erroneous deprivation of benefits.

(3) Governmental Interest

The governmental interest that must be considered is ensuring that only truly disabled individuals are receiving reasonable and necessary medical treatment. *Sullivan II* at 8. The government also

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[27] Most of the Plaintiffs before us were subjected to the reconsideration review process as the termination of their medical benefits occurred prior to the amendment to the Act. *See* Am. Compl. ¶¶ 102, 105, 129, 163, 181, 198, 216, 254.

has an interest in containing the rising costs of medical care and insurance payments. Indeed, cost containment is the purpose behind the supersedeas provisions in question here. Further, the government has an interest in conserving its scarce fiscal and administrative resources, and an increase in pre-deprivation procedures may well be an added burden upon those resources. While we agree that such legitimate interests exist, we are also aware that the government has an interest in not wrongfully depriving medical benefits to disabled individuals and ensuring that employees who reasonably and legitimately need medical care under the Act will continue to receive it. On balance, therefore, we are not convinced that any governmental interest outweighs the private interest we have discussed above and which favors Sullivan. Thus, we conclude that the denial of any pre-deprivation process cannot be sustained.

C. What Process is Due

Now that we have weighed the three factors under the *Mathews* analysis, and concluded that § 531(5) and (6) do not adequately suffice to protect Sullivan's due process interests, we must decide how much process to afford employees receiving medical benefits under the Act prior to the termination of such benefits.

In only one case, *Goldberg v. Kelly*, 397 U.S. 306 (1970), which involved subsistence welfare benefits, has the Court required a full evidentiary hearing prior to the deprivation. In contrast, in *Mathews*, the Court concluded that an evidentiary hearing was not necessary before an individual was deprived of his/her Social Security benefits because, unlike the welfare benefits at issue in *Goldberg*, the disability payments were less likely to be the individual's sole source of income. The Court held that notice of the proposed reasons for the termination and advice as to how the recipient could obtain and submit additional information prior to the termination was sufficient to comport with pre-deprivation due process procedure. Similarly, in *Loudermill*, the Supreme Court determined that due process required that a tenured public employee be given oral or written notice of the charges against him/her, an explanation of the employer's evidence, and an opportunity to present her position prior to termination of her position. *See* 470 U.S. at 546.

While we believe that additional procedural safeguards will cure the problems currently at issue with the supersedeas provisions, due process does not require a *Goldberg*-style evidentiary hearing prior to the deprivation of medical benefits. Utilization review is premised upon "routine, standard, and unbiased medical reports," *Mathews*, 424 U.S. at 344 (quoting *Richardson v. Perales*, 402 U.S. 389, 404 (1971)), from the treating physician, reviewed by a physician in the same specialty who assesses the case based upon generally accepted medical protocols, principles, and practices. Issues of credibility and veracity are less likely to be an issue in such a case. Accordingly, the potential benefit of a pre-termination evidentiary hearing — or even an oral presentation to the medical reviewer — is substantially less in this context than in a *Goldberg*-context. *See, e.g., Mathews*, 424 U.S. at 344-45.

Nevertheless, we think that at a minimum the employee should be granted the opportunity to present additional evidence such as his/her personal testimony in writing as to the reasonableness and necessity of the disputed treatment, as this could significantly lessen the risk of erroneously depriving an employee of his/her medical benefits. This may be particularly true for the recipient of unorthodox, naturopathic, or non-traditional medical treatments — such as, for example, acupuncture or chiropractic manipulation. Without some sort of indication from the very individual who is receiving the questioned medical treatment as to its success or the employee's improvement, the risk of erroneously terminating an employee's medical benefits is too high.

We are ever mindful of the fact that the supersedeas provision contested in this case applies only to *disabled* workers who may experience chronic pains over the course of several years. Many of these workers may be disabled for life. The personal written submission of such disabled workers is critical to assessing the relative benefits that a particular treatment or practice might have. While reading medical reports and reviewing patients' charts might appear to show relatively slight improvement, suggesting that the medical treatment is unreasonable or unnecessary, a particular

treatment might be the only medical treatment that alleviates an individual's pain or mitigates the severity of his/her symptoms. As the utilization review process concerns itself only with the specific medical practice that is being challenged, *see* 34 Pa. Code § 127.470, the reviewing physician may have little or no perspective as to how a particular treatment is benefitting the patient in the context of the overall medical care that the employee has undergone during the course of his/her disability.[28] The opportunity for the employee to present his/her side of the story — to introduce his/her own personal account as to how the particular treatment has ameliorated his/her condition — may be highly relevant to the URO's determination and may not be adequately reflected or documented in the medical reports.

Cognizant of the governmental interest, we believe that this additional procedural safeguard of permitting an employee to submit his/her personal account in writing of the reasonableness or necessity of the disputed medical treatment would not prove unduly onerous or administratively burdensome or costly to implement. To the contrary, the present procedures could remain intact but with the exception that the employee be notified at a meaningful time and in a meaningful manner (prior to the termination of his/her medical benefits) that he/she can submit, if he/she so chooses, a letter or a statement to the URO regarding the reasonableness or necessity of his/her medical treatment. The reviewing physician could then consider the employee's account as part of the evidence considered when making his/her determination. We are not persuaded that this type of evidence would pose a problem for the reviewing physician, as doctors regularly make judgments about the course of treatments depending upon the input from their patients. The reviewing physician as part of the utilization review process

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[28] While we recognize that the regulations require that a URO attempt to obtain a complete set of medical records from all of an employee's medical providers for a particular injury, *see* 34 Pa. Code. § 127.462, there is no guarantee that all of an employee's records will be located, received, and reviewed during the utilization review. In any event, medical records provide but one component for consideration before an employee is deprived of his/her constitutionally protected interest in his/her medical benefits.

would simply consider the employee's account of the medical treatment before rendering judgment.

In sum, we hold that the supersedeas provisions under § 531(5) and (6) violate the dictates of due process by not affording disabled employees notice or an opportunity to be heard before their medical benefits are suspended. To remedy the procedural defects in the statute, at a minimum, an employee must be given: (1) timely and reasonable notice of the imminent suspension of the medical benefits and treatment before the suspension takes effect; (2) a description of the reasons why utilization review has been invoked; (3) an opportunity and time to submit a personal statement in writing regarding the employee's view of the reasonableness and/or necessity of the disputed medical treatments; and (4) a description of the procedures under which the employee can appeal an adverse determination.

V.

In addition to the deficiencies we have discussed regarding the Commonwealth's statutes, we now consider whether the regulations governing utilization review provide adequate guidance to UROs and ALJs. We hold that they do.

Sullivan claims that the regulations governing utilization review fail to provide standards for determining whether the contested medical treatment is reasonable or necessary. Without such standards, Sullivan contends that the decisions by the UROs and ALJs are *ad hoc*, arbitrary, and without any consistency among the various UROs or ALJs such that those decisions violate her right to procedural due process under the Fourteenth Amendment. We cannot agree.

The district court properly held that the regulations in question provide sufficient guidance to reviewing physicians and ALJs to comport with due process. As in any case that is subject to utilization review, the inquiry solely focuses upon whether the medical treatment in question is reasonable and/or necessary. *See* 34 Pa. Code § 127.470. In so doing, the regulations provide that the reviewing physician must be of the same specialty as the treating physician, *see* 77 Pa. Const. Stat. Ann. § 531(6)(i), and that the reviewer must analyze the disputed treatment in light of

generally accepted medical protocols. *See* 34 Pa. Code § 127.467. The reviewing physician may not consider whether the injury being treated is work-related, whether the employee continues to be disabled, whether the employee has reached maximum medical improvement, or whether the fees assessed for the services provided are reasonable. *See id.* § 127.470. Furthermore, the reviewer must provide a detailed opinion in writing that explains the basis for his/her determination. *See id.* § 127.472. Accordingly, the regulations provide guidelines which serve to provide necessary guidance to the reviewing physician concerning the appropriate bases for his/her determination such that the ultimate determinations are not arbitrary and do not discriminate.

Similarly, the *de novo* hearings before Workers' Compensation ALJs also comport with due process. As in any administrative hearing, the ALJ hears testimony, considers evidence, and renders decisions consistent with the applicable law. At these *de novo* hearings, an employee has the opportunity to present his/her own medical expert, the right to cross-examination of the witnesses, and the right to present additional evidence to support his/her claim. Further, the statute provides that the ALJ shall consider — but is not bound by — the report from the utilization review. *See* 77 Pa. Const. Stat. Ann. § 531(6)(iv). There is no indication that the *de novo* hearings in the utilization review context suffer from any different procedure or lack of guidance than any other administrative hearing of which we are aware. Accordingly, we hold that the regulations provide sufficient guidance to the reviewing physicians and the ALJs in evaluating employees' cases such that the employees' rights to procedural due process are honored.

VI.

We now address whether imposing the costs of reconsideration review upon a losing employee — without giving him/her proper notice beforehand — violates due process.

Before the amendments in Act 57, if either party disagreed with the decision rendered by the URO, that party could petition the Bureau for reconsideration review within thirty (30) days of receiving the decision. *See* 34 Pa. Code § 127.502(a). Unlike the initial utilization review, however, where the employer or insurer

paid for the review, the Bureau advanced the costs of reconsideration review and charged the losing party for the cost thereafter. While Act 57 eliminated reconsideration review, Act 57 did not become effective until August 23, 1996, nearly three months after the amended complaint in this action was filed. Thus, most of the Plaintiffs before us were subjected to the costs of reconsideration review when they suffered an adverse decision upon reconsideration. It is unclear from the undeveloped record below, however, whether any of the Plaintiffs actually paid these reconsideration fees.

Sullivan contends that the imposition of a fee upon a losing employee violated an employee's right to due process because such a fee was imposed without any notice, without an opportunity to be heard on the underlying contested claim, and without any consideration for the employee's ability to pay. There was no *in forma pauperis* status for reconsideration. Sullivan further asserts that such a scheme violated the liberty interests of employees because one may have foregone reconsideration review rather than risk paying the substantial costs of reconsideration if he/she lost.[29]

We do not decide whether the imposition of costs on reconsideration without notice violated the dictates of due process. As the Act has been amended, reconsideration review no longer exists, these fees are no longer imposed, and thus, this is not a continuing problem. Further, given the undeveloped record, we cannot determine whether any of the Plaintiffs, in fact, paid these fees. Accordingly, we remand to the district court to determine whether any of the Plaintiffs paid the costs of reconsideration, what those costs were, and to re-examine the possible constitutional difficulties that the imposition of reconsideration fees poses.

VII.

At this juncture, we raise an Eleventh Amendment sovereign immunity issue *sua sponte* as it is relevant to our jurisdiction over the Commonwealth Defendants. *See V-1 Oil Co. v. Utah State Dep't of Pub. Safety*, 131 F.3d 1415, 1419 (10th Cir. 1997)

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[29] The costs of reconsideration review varies. The typical charge is several hundred dollars. *See* Am. Compl. ¶ 77.

(raising Eleventh Amendment sovereign immunity *sua sponte*); *Suarez Corp. Indus. v. McGraw*, 125 F.3d 222, 227 (4th Cir. 1997) ("We believe that, because of its jurisdictional nature, a court ought to consider the issue of Eleventh Amendment immunity at any time, even *sua sponte*."); *Atlantic Healthcare Benefits Trust v. Googins*, 2 F.3d 1, 4 (2d Cir. 1993) (raising Eleventh Amendment issue *sua sponte*); *Charley's Taxi Radio Dispatch Corp. v. Sida of Hawaii, Inc.*, 810 F.2d 869, 873 n.2 (9th Cir. 1987) (same); *but see Bouchard Transp. Co. v. Florida Dep't of Envtl. Protection*, 91 F.3d 1445, 1448 (11th Cir. 1996) (stating that the "Eleventh Amendment is not jurisdictional in the sense that courts must address the issue *sua sponte*").

The Eleventh Amendment[30] confers sovereign immunity upon the States such that they cannot be subject to suit in district court absent either Congressional intent to abrogate that immunity enacted pursuant to a valid exercise of power, *see Seminole Tribe v. Florida*, ___ U.S. ___, 116 S. Ct. 1114, 1123 (1996), or a State's explicit consent. *See Port Auth. Trans-Hudson Corp. v. Feeney*, 495 U.S. 299, 304 (1990). The Eleventh Amendment, however, does not immunize State officials for actions taken in their individual capacities. *See Scheuer* v. *Rhodes*, 416 U.S. 232, 237-38 (1974).

The amended complaint does not make clear whether the Plaintiffs have brought suit against the Commonwealth Defendants in their official or individual capacities, or both. We leave this for the district court to decide. If the district court determines that the Commonwealth Defendants have only been sued in their official capacities, the district court — in its discretion — may allow the Plaintiffs to amend their complaint to include those Defendants in their individual capacities. In any event, the district court will be

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30 The Eleventh Amendment provides:

> The Judicial power of the United States shall not be construed to extend to any suit in law or equity, commenced or prosecuted against one of United States by Citizens of another State, or by Citizens or Subjects of any Foreign State.

U.S. Const. amend. XI.

obliged to address whether redress can be sought against the Commonwealth Defendants in federal court under Eleventh Amendment proscriptions.

VIII.

In conclusion, we hold that the supersedeas provisions of 77 Pa. Const. Stat. Ann. § 531(5) and (6), are unconstitutional in that they violate an employee's procedural due process rights by failing to provide adequate notice that his/her medical benefits may be suspended upon the invocation of utilization review and by not granting the employee an opportunity to respond in writing before that termination takes effect. We also hold that the private insurance companies are state actors and thus may be joined in a § 1983 action when they elect to invoke the supersedeas provisions to terminate or suspend an employee's constitutionally protected interests in receiving medical benefits.

Thus, we will reverse the order of the district court dismissing Sullivan's complaint and will remand to the district court for further proceedings in accordance with this opinion. On remand, among other issues, the district court should address the issue of reconsideration fees, the question of certifying a class, and for the first time, it should consider whether it has subject matter jurisdiction over the Commonwealth Defendants in light of Eleventh Amendment sovereign immunity.

A True Copy:

Teste:

Clerk of the United States Court
of Appeals for the Third Circuit

APPENDIX B

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

No. 96-2140

DELORES SCOTT SULLIVAN; WILLIAM BATTLE; ANTHONY CANCILA; CHARLES MATTHEWS; CHRISTOPHER COSTELLO; LISA LEX; SUSAN HANSEN, On Their Own Behalf and on Behalf of All Similarly Situated Class Plaintiffs; PHILADELPHIA AREA PROJECT ON OCCUPATIONAL SAFETY AND HEALTH; THE PHILADELPHIA FEDERATION OF TEACHERS, Local 3, AFL-CIO

v.

ROBERT BARNETT, Secretary of Labor and Industry for the Commonwealth of Pennsylvania; FRANK BEAL, Director of the Pennsylvania Bureau of Workers Compensation; CONSTANCE B. FOSTER, Insurance Commissioner for the Commonwealth of Pennsylvania; CATHERINE BAKER KNOLL, Treasurer, Commonwealth of Pennsylvania; JOHN P. O'MALLEY, Director, State Workers' Insurance Fund; AMERICAN MANUFACTURERS MUTUAL INSURANCE COMPANY; CIGNA CORPORATION; CONTINENTAL CASUALTY COMPANY; USF&G INSURANCE COMPANY; ZURICH AMERICAN INSURANCE COMPANY; SCHOOL DISTRICT OF PHILADELPHIA; JOHNNY J. BUTLER, Secretary of Labor and Industry of the Commonwealth of Pennsylvania; RICHARD A. HIMLER, Director of the Pennsylvania Bureau of Workers Compensation; COMMERCIAL UNION INSURANCE COMPANY; DONEGAL MUTUAL INSURANCE COMPANY; HARTFORD INSURANCE COMPANY

Delores Scott Sullivan, William Battle, Louis Baumgartner*, Anthony Cancila, William C. Dillon*, Terrence Ervine*, Charles

Matthews, Christopher Costello, Lisa Lex, Susan Hansen, Philadelphia Area Project on Occupational Safety and Health and Philadelphia Federation of Teachers,

Appellants

*pursuant to Rule 12(a) FRAP

On Appeal from the United States District Court
from the Eastern District of Pennsylvania
(D.C. No. 95-cv-00201)

Present: Mansmann, Nygaard and Garth, *Circuit Judges*

JUDGMENT

This cause coming on to be heard on the record from the United States District Court for the Eastern District of Pennsylvania and was argued by counsel on September 11, 1997.

On consideration whereof, it is now here ordered and adjudged by this Court that the supersedeas provisions of 77 Pa. Const. Stat. Ann. sections 531(5) and (6) are unconstitutional in that they violate an employee's procedure due process rights by failing to provide adequate notice that his/her medical benefits may be suspended upon the invocation of utilization review and by not granting the employee an opportunity to respond in writing before that termination takes effect. It is also ordered and adjudged that the private insurance companies are state actors and thus may be jointed in a section 1983 action when they elect to invoke the supersedeas provisions to terminate or suspend an employee's constitutionally protected interests in receiving medical benefits. Thus, the judgment of the said District Court entered December 19, 1996, is hereby reversed and the cause is remanded to the District Court for further proceedings in accordance with this opinion. On remand, among other issues, the District Court should address the issue of reconsideration fees, the question of certifying a class, and

for the first time, it should consider whether it has subject matter jurisdiction over the Commonwealth Defendants in light of the Eleventh Amendment sovereign immunity.

Costs taxed against appellees.

All of the above in accordance with the opinion of this Court.

ATTEST:

Clerk

Dated: 13 March 1998

Certified as a true copy and issued in lieu of a formal mandate on 21 April 1998

Teste:

Clerk, United States Court of Appeals for the Third Circuit

APPENDIX C

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

DELORES SCOTT SULLIVAN, et al., Plaintiffs,	:	CIVIL ACTION
	:	NO. 95-201
v.	:	
ROBERT BARNETT, et al., Defendants,	:	

MEMORANDUM

BUCKWALTER, J. January 24, 1996

I. BACKGROUND

Plaintiffs in this putative civil rights class action claim to be persons who had been receiving medical benefits pursuant to the Pennsylvania Worker's Compensation Law, and who were thereafter deprived of those benefits without prior notice or an opportunity to be heard pursuant to what plaintiffs' counsel characterize as an "automatic supersedeas" as provided by Section 306(f.1)(5) of the aforesaid law, as amended, 77 P.S. 531(5) (Supp. 1994), which provides in part as follows:

> The employer or insurer shall make payment and providers shall submit bills and records in accordance with the provisions of this section. All payments to providers for treatment provided pursuant to this act shall be made within thirty (30) days of receipt of such bills and records unless the employer or insurer disputes the reasonableness or necessity of the treatment provided pursuant to paragraph (6). A provider who has submitted the reports and bills required by this section and who disputes the amount or timeliness of the payment from the employer or insurer shall file an application for fee review with the department. Within thirty (30) days of the filing of such an application, the department shall render an administrative decision.

Paragraph 6 provides, in part, as follows:

Except in those cases in which a referee asks for an opinion from peer review under section 420, disputes as to reasonableness or necessity of treatment by a health care provider shall be resolved in accordance with the following provisions:

(i) The reasonableness or necessity of all treatment provided by a health care provider under this act may be subject to prospective, concurrent or retrospective utilization review at the request of an employe, employer or insurer. The department shall authorize utilization review organizations to perform utilization review under this act. Organizations not authorized by the department may not engage in such utilization review.

(ii) The utilization review organization shall issue a written report of its findings and conclusions within thirty (30) days of a request. If the provider, employer, employe or insurer disagrees with the finding of the utilization review organization, a request for reconsideration must be filed no later than thirty (30) days after receipt of the utilization review report. The request for reconsideration must be in writing.

(iii) The employer or the insurer shall pay the cost of the initial utilization review. The party which does not prevail on reconsideration of an initial review shall bear the costs of such reconsideration.

(iv) If the provider, employer, employe or insurer disagrees with the finding of the utilization review organization on reconsideration, a petition for review by the department must be filed within thirty (30) days after receipt of the reconsideration report. The department shall assign the petition to a referee for a hearing.

The "automatic supersedeas" to which plaintiffs refer is implemented by regulations which, as of November 11, 1995, provide in part as follows. All regulations hereafter set forth come from exhibits supplied to the court by plaintiffs' counsel.

§127.208. Time for payment of medical bills.

(a) Payments for treatment rendered under the act shall be made within 30 days of receipt of the bill and report submitted by the provider.

(e) The 30-day period in which payment shall be made to the provider may be tolled only if review of the reasonableness or necessity of the treatment is requested during the 30-day period under the UR provisions of Subchapter C (relating to medical treatment review). The insurer's right to suspend payment shall continue throughout both the initial review and the reconsideration review of the UR process. The insurer's right to suspend payment shall further continue beyond the UR process to a proceeding before a Workers' Compensation judge, unless there is a UR determination made at reconsideration that the treatment is reasonable or necessary.

(f) If a URO determines that medical treatment is reasonable or necessary, at reconsideration, the insurer shall pay for the treatment. Filing a petition for review before a Workers' Compensation judge, does not further suspend the obligation to pay for the treatment once there has been a determination at reconsideration that the treatment is reasonable or necessary. If it is finally determined that the treatment was not reasonable or necessary, and the insurer paid for the treatment in accordance with this chapter, the insurer may seek reimbursement from the Supersedeas Fund under section 443(a) of the act (77 P.S. §999).

The Utilization Review (UR) provisions of Subchapter C relating to medical treatment review provide in part as follows:

§127.401. Purpose - review of medical treatment.

(a) Section 306(f.1)(6) of the Act provides a utilization review (UR) process, intended as an impartial review of the reasonableness or necessity of medical treatment rendered to, or proposed for, work-related injuries and illnesses.

(b) UR is a three-step process, that may be requested by multiple parties:

1. The first-step is the initial request that may be made by, or on behalf of, the employer, insurer or employe.

2. The second-step is the request for reconsideration that may be made by, or on behalf of the employer, insurer, employe or health care provider.

3. The third-step is the petition for review of utilization review, that may be filed by, or on behalf of, the employer, insurer, employe or health care provider.

(c) Review of medical treatment shall be conducted only by those organizations authorized as utilization review organizations (UROs) by the Secretary, pursuant to the process set forth in §127.650 through §127.670.

§127.403. Assignment of cases to UROs.

The Bureau will randomly assign requests for UR to authorized UROs. An insurer's obligation to pay medical bills within 30 days of receipt shall be tolled only when a proper request for UR has been filed with the Bureau in accordance with the provisions of this Subchapter.

§127.451. Initial requests for utilization review - who may file.

Initial requests for UR may be filed by an employe, employer or insurer. Health care providers may not file initial requests for UR.

§127.452. Initial requests for utilization review - filing and service.

(a) A party seeking UR of treatment rendered under the Act shall file the original and 8 copies of a form prescribed by the Bureau as an initial request for utilization review. All information required by the form must be provided. Where available, the filing party shall attach authorizations to release medical records of the providers listed on the request.

(b) The initial request for UR shall be served on all parties and their counsel (if known) and the proof of service

on the form shall be executed. If the proof of service is not executed, the request for UR will be returned by the Bureau.

(c) Initial requests for UR shall be sent to the Bureau at the address listed on the form.

§127.453. Initial requests for utilization review - assignment by the Bureau.

(a) The Bureau will randomly assign a properly filed request for UR to a certified URO (Utilization Review Organization).

(b) The Bureau will send a notice of assignment of the request for UR to the URO; the employe; the employer or insurer; the health care provider under review, and the attorneys for the parties, if known.

§127.476. Duties of UROs - form and service of determinations.

(a) Each determination rendered by a URO on the merits shall include a form prescribed by the Bureau as a medical treatment review determination face sheet and the reviewer's report. The face sheet shall be signed by an authorized representative of the URO.

(b) When a determination is rendered against the provider under review on the basis that no records were supplied by the provider, the determination shall consist only of the face sheet. However, in such cases, the face sheet shall clearly indicate that the basis for the decision is the failure of the provider under review to supply records to the URO.

(c) The URO's determination, consisting of both the face sheet and the reviewer's report, shall be served on the employe, the insurer or employer, the provider under review, the attorneys for the parties (if known), and the Bureau.

(d) The URO shall also serve a copy of a form prescribed by the Bureau for filing requests for reconsideration on all parties and their attorneys (if known).

§127.501. Reconsideration of initial utilization review determinations - who may file.

If the provider under review, the employe, the employer or the insurer disagrees with the initial UR determination rendered, a request for reconsideration may be filed with the Bureau.

§127.502. Reconsideration - time for filing.

Within 30 days of receipt of the initial UR determination the party requesting reconsideration shall file with the Bureau the original and 8 copies of the form prescribed by the Bureau as a request for reconsideration. Requests for reconsideration shall be sent to the Bureau at the address listed on the form.

§127.503. Reconsideration - service.

(a) The request for reconsideration shall be served on all parties and their attorneys (if known). The proof of service on the request for reconsideration shall be executed.

§127.509. Assignment of reconsideration to reviewer by URO.

(a) The URO shall forward the medical records used for the initial UR, together with any additional records supplied by the provider under review, to a reviewer other than the reviewer who performed the initial UR. The reviewer performing the reconsideration shall be licensed by the Commonwealth of Pennsylvania in the same profession and Board-certified in the specialty or sub-specialty of the provider under review. In the case of physicians, Board-certification shall be by an accredited specialty board.

§127.512. Reconsideration - form and service of determination.

(a) The determination by a URO on a reconsideration shall be in the form prescribed by §127.476 (relating to form and services of determinations).

(b) The determination by a URO on a reconsideration shall be served in accordance with the requirements prescribed by §127.476 (relating to form and service of determinations).

§127.551. Petition for Review by Bureau of utilization review determination.

If the provider under review, the employe, the employer or the insurer disagrees with the determination rendered on reconsideration, a request for review by the Bureau may be filed on a form prescribed by the Bureau as a petition for review of a utilization review determination.

§127.556. Petition for Review by Bureau - *de novo* hearings.

The hearing before the Workers' Compensation Judge shall be a *de novo* proceeding. The Workers' Compensation Judge shall not be bound by any prior determinations made during the UR process.

Based substantially upon the above referenced law and regulations (and arguably some not set forth above); the deposition testimony of David R. Weyl, Chief of the Medical Cost Containment Division, Bureau of Workers' Compensation, Department of Labor and Industry, Commonwealth of Pennsylvania; Laura S. Keller, manager of the medical treatment, review section for the Bureau of Workers' Compensation; Carl M. Lorine, a current Workers' Compensation Judge; and Cheryl M. Lapotin, Workers' Compensation claims manager for the School District of Philadelphia, plaintiffs contend that both the defendant private insurers and the defendant school district, acting through its third party administrator, are acting jointly with the state when they "unilaterally terminate medical benefits pursuant to the utilization review." (Pls.' Br. at 18).

II. DISCUSSION

The question presented in connection with defendants' motions to dismiss and plaintiffs' motion for partial summary judgment is: Are the private insurer defendants and school district defendants state actors?[1]

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[1] Since defendants' motions contested factual allegations in the plaintiffs' complaint and appeared to rely upon facts outside the complaint, plaintiffs moved the court to permit them to take a limited amount of discovery prior to answering the motions and to convert the motions to

In *Mark v. Borough of Hatboro*, 51 F.3d 1137 (3d Cir. 1995), the court reiterated the Supreme Court's pronouncement that in cases under §1983, such as this case, "under color" of law is treated as the same thing as the "state action" requirement of the Fourteenth Amendment. *Mark*, 51 F.3d at 1141 citing *United States v. Price*, 383 U.S. 787, 794 n.7, 86 S. Ct. 1152, 1157 n.7, 16 L. Ed. 2d 267 (1966) (quoted in *Lugar v. Edmonson Oil Co.*, 457 U.S. 922, 928, 102 S. Ct. 2744, 2749, 73 L. Ed. 2d 482 (1982) ... and *Rendell-Baker v. Kohn*, 457 U.S. 830, 838, 102 S. Ct. 2764, 2769-70, 73 L. Ed. 2d 418 (1982). The court went on to recite the three discrete tests to determine whether there has been state action. They are:

(1) Does the private entity exercise powers that are traditionally the exclusive prerogative of the state.

(2) Has the private entity acted with the help of or in concert with state officials.

(3) Has the state so far insinuated itself into a position of interdependence with the private entity that it must be recognized as a joint participant in the challenged activity (sometimes referred to as the symbiotic relationship test). *Mark*, 51 F.3d at 1142-1143 (citations omitted).

A. Private Insurer Defendants.

Plaintiffs contend that the relationship between the state and the private insurer defendants in utilization review ("UR") is "so interstitial as to render the defendants state actors for purposes of the Fourteenth Amendment when they involve utilization review and cease, or supersede, medical benefits to claimants on that basis." (Pls.' Br. at 2-3).

The facts upon which plaintiffs seem to rely to justify the above conclusion are the following:

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dismiss to motions for summary judgment. The court permitted plaintiffs a period of forty-five (45) days to conduct discovery on the issue of state action. The discovery period was subsequently extended to July 14, 1995. Oral argument on the motions was held on December 13, 1995.

1. The historical roots of the Workers' Compensation Act, and the system it created.

It is mandatory under the act that employers provide workers' compensation for their employees. In exchange, the employee is required to relinquish his right to sue his employer in tort. While the employee has the right to have insurance coverage at no cost, he has no right to opt out of the workers' compensation system in favor of his own private insurance coverage or none at all.

2. The operation of the Workers' Compensation System.

The Bureau of Workers' Compensation of the Pennsylvania Department of Labor and Industry (hereafter "Bureau"), is the administrator of the Workers' Compensation Act and has adopted its own rules and regulations by which it actively enforces the Act and ensures compliance with it. The Bureau has adopted forms to be used for various reporting requirements included in the Act.

3. Bureau's specific role in the utilization review process under 77 P.S. §531(5) and regulations.

"The Bureau serves the dual function of gate keeper and traffic cop" (Pls.' Br. at 12) in that access to the utilization review system can only be gained by filing the Bureau's form. Once that form has been completed properly and submitted in timely fashion, an insurer may stop payments for medical treatment. In order for its obligation to pay medical bills to be tolled, the insurer must submit a proper request for UR within 30 days of receipt of the medical bills. The propriety of the request as initially determined by the Bureau is based solely upon formal issues regarding the Bureau's form and involves no consideration of the merits of the request. If the formal requirements of the form are met, the Bureau then assigns the case to a Utilization Review Organization ("URO"). When the URO completes its report, it must file a copy of it with the Bureau. Any party — that is, employer, insurer, provider or employe — may file for reconsideration, after which filing the Bureau assigns the case to a URO for review. The URO performing this reconsideration review must file a copy of its report with the Bureau.

Any party aggrieved by the reconsideration review may file a petition for review with the Bureau, which assigns it to a Workers' Compensation judge, who considers the matter *de novo*. While the employe cannot participate in either the initial UR or the reconsideration review, he can participate fully in the de novo proceeding before the Workers' Compensation judge.

Essentially, plaintiffs argue that insurer defendants are state actors when they request a UR because (1) the state has created the workers' compensation system which is administered by the Bureau; (2) the insurer can only access the system by the use of official forms prepared by the state through the Bureau; and (3) the insurers will not be permitted to toll payments of medical benefits unless the forms they file comply with the Bureau's procedural provisions and "substantive criteria" permitted by statute or regulations.[2]

The insurer defendants argue that contrary to being state actors, they are private entities who independently make a decision whether to request utilization review. Once they decide to seek UR, the statute "is self-executing, meaning that the obligation to make payment is determined solely by whether or not there has been a request by the employer or insurer for utilization review." (Defs.' Mem at 2). Because the decision to seek UR is made independently, insurer defendants argue, "the determination of whether or not there is a payment obligation does not depend on the actions of any public agency or official." (*Id.*)

Before embarking on an evaluation of the specific facts of the present case, I feel it is important to note the basic constitutional principles relevant to the discussion of this case. As the Supreme Court stated in *Edmonson v. Leesville Concrete Co., Inc.*, 500 U.S. 614, 111 S. Ct. 2077, 114 L. Ed. 2d 660 (1991):

> One great object of the Constitution is to permit citizens to structure their private relations as they choose subject only to the constraints of statutory or decisional law.

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[2] For a discussion of whether the criteria examined by the Bureau are in fact "substantive" or merely procedural, see this opinion, *infra* at ___.

> To implement these principles, courts must consider from time to time where the governmental sphere ends and the private sphere begins. Although the conduct of private parties lies beyond the Constitution's scope in most instances, governmental authority may dominate an activity to such an extent that its participants must be deemed to act with the authority of the government and, as a result, be subject to constitutional constraints. This is the jurisprudence of state action, which explores the "essential dichotomy" between the private sphere and the public sphere, with all its attendant constitutional obligations.

Edmonson, 500 U.S. at 619-620, 111 S. Ct. 2083 (citations omitted). It is with these considerations in mind that I proceed with the following analysis.

In *Lugar v. Edmondson Oil Co.*, 457 U.S. 922, 102 S. Ct. 2744, 73 L. Ed. 2d 482 (1982), the Supreme Court set forth the test now relied upon in evaluating state action questions under Section 1983. That framework is utilized and effectively explained by the court in the more recent case of *Edmonson v. Leesville Concrete*. Since this analytical framework appears to have been taken up by the Third Circuit, *see, e.g., Mark*, 51 F.3d 1137, I have attempted to follow what I will call the *Edmonson/Lugar* test in answering the question presented here.

The *Edmonson/Lugar* test consists of two basic questions:

(1) Has the claimed constitutional deprivation resulted from the exercise of a right or privilege having its source in state authority; and

(2) Can the private entity charged with the deprivation be described in all fairness as a state actor.

Edmonson, 500 U.S. at 620, 111 S. Ct. at 2082 and 2083.

In *Lugar*, the first of the two basic questions was answered the same way as the question should be answered in this case; namely, the procedural scheme created by the statute obviously is the product of state government and the statute has its source in state authority. However, both *Lugar* and *Edmonson* make it clear that this is only the beginning of the inquiry.

The second question, involves an examination of the following fact-based elements:

(1) The extent to which the private entity relies on governmental assistance and benefits;

(2) Whether the private entity is performing a traditional government function; and

(3) Whether the injury caused is aggravated in a unique way by the incidents of governmental authority.

Edmonson, 500 U.S. at 621-622, 111 S. Ct. at 2083 citing *Lugar*, 457 U.S. at 942, 102 S. Ct. at 2754-2756.

In connection with the first element of the second question, the Court in *Edmonson* instructed that private use of state-sanctioned private remedies alone does not rise to state action unless private parties make extensive use of state procedures with the "overt, significant assistance of state officials." *Edmonson*, 500 U.S. at 622, 111 S. Ct. at 2083, 2084 (quoting *Tulsa Professional Collection Services, Inc. v. Pope*, 485 U.S. 478, 485, 108 S. Ct. 1340, 1345, 99 L. Ed. 2d 565 (1988) (additional citations omitted). *Lugar* and *Edmonson* provide examples of overt, significant assistance of state officials. *See also Sniadach v. Family Finance Corp. of Bay View*, 395 U.S. 337, 89 S. Ct. 1820, 23 L. Ed. 2d 349 (1969).

In *Lugar*, the prejudgment attachment procedure required only that the plaintiff allege in an ex parte petition that defendant was disposing of his property (or might dispose of it) to defeat his creditors. Upon receiving this petition, the clerk in the state court would issue a writ of attachment which was then executed by the Sheriff. Although the property was left in defendant's possession, the execution of the writ of attachment by the Sheriff effectively sequestered it. Thus, in *Lugar*, and earlier in *Sniadach*, the court held that a private party's joint participation with state officials in the seizure of disputed property is sufficient to characterize the private party, in all fairness, a "state actor" for purposes of the Fourteenth Amendment.

However, *Lugar*, upon which plaintiffs rely substantially, seems to be limited to the context of prejudgment attachment.

Lugar, 457 U.S. at 939, n.21, 102 S. Ct. 2755, n.21. As noted by the Court in *Lugar*, the question of whether a private entity in all fairness can be described as a state actor is a "fact bound" one, and so the ruling in one case may not necessarily be extrapolated to another case's fact pattern.

The *Edmonson* case decided that a private litigant in a civil case who uses peremptory challenges to exclude jurors on account of race, has to in all fairness be deemed a government actor.

In summarizing the extent to which a private party relied on government assistance, the Court in *Edmonson* carefully analyzed the facts of the case and the functions of the private and state participants in the jury selection process, stating:

> As we have outlined here, a private party could not exercise its peremptory challenges absent the overt, significant assistance of the court. The government summons jurors, constrains their freedom of movement, and subjects them to public scrutiny and examination. The party who exercises a challenge invokes the formal authority of the court, which must discharge the prospective juror, thus effecting the "final and practical denial" of the excluded individual's opportunity to serve on the petit jury. *Virginia v. Rives*, 100 U.S. 313, 322, 25 L. Ed. 667 (1880). Without the direct and indispensable participation of the judge, who beyond all question is a state actor, the peremptory challenge system would serve no purpose. By enforcing a discriminatory peremptory challenge, the court "has not only made itself a party to the [biased act], but has elected to place its power, property and prestige behind the [alleged] discrimination." *Burton v. Wilmington Parking Authority*, 365 U.S. 715, 725, 81 S. Ct. at 862. In so doing, the government has "create[d] the legal framework governing the [challenged] conduct," *National Collegiate Athletic Assn.*, 488 U.S. at 192, 109 S. Ct. at 462, and in a significant way has involved itself with invidious discrimination.

Edmonson, 500 U.S. at 624, 111 S. Ct. 2084-2085. In addition, *Edmonson* then considered the other two factors in deciding whether a private entity in all fairness can be described as a state actor, and concluded that the action in question involved a

traditional government function (selection of a jury) and was aggravated in a unique way because the government permits the discrimination to occur within the courthouse.

The above cases, involving joint participation with state officials in the seizure of property and the private litigants' use of peremptory challenges to exclude jurors on account of race, are examples of governmental assistance and benefits which have been sufficiently extensive to support an ultimate finding of "state actor" according to the test outlined in *Edmonson*.

Into the above category also must fall a case arising from this district which cannot be overlooked because it deals with a challenge to a past method by which an employer or insurer obligated to pay benefits under the Pennsylvania Workers' Compensation Act could cease paying those benefits: *Baksalary v. Smith*, 579 F. Supp. 218 (1984).

The section of the Act involved in *Baksalary* provided, in part:

> The filing of a petition to terminate or modify a notice of compensation payable or a compensation agreement or award as provided in this section shall operate as a supersedeas, and shall suspend the payment of compensation fixed in the agreement or by the award, in whole or to such extent as the facts alleged in the petition would, if proved, require only when such petition alleges that the employe has returned to work at his prior or increased earnings or where the petition alleges that the employe has fully recovered and is accompanied by an affidavit of a physician on a form prescribed by the [Bureau of Worker's Compensation] to that effect which is based upon an examination made within fifteen days of the filing of the petition.

77 P.S. § 774 (1992).

The rationale of the *Baksalary* court with regard to the state actor issue of private insurers can best be summed up by the following:

> The Supreme Court has "consistently held that a private party's joint participation with state officials in the seizure of disputed property is sufficient to characterize that party as a

> 'state actor' for purposes of the Fourteenth Amendment." *Lugar*, 457 U.S. at 941, 102 S. Ct. at 2756. "[I]n this context 'joint participation' [does not require] something more than invoking the aid of state officials to take advantage of state created attachment procedures." 457 U.S. at 942, 102 S. Ct. at 2756.
>
> Section 413's automatic supersedeas procedure requires a filing with the Bureau of Worker's Compensation. This filing is sufficient to constitute "joint participation" and to subject private invocation of the automatic supersedeas to the due process clause.

Baksalary, 579 F. Supp. 231, 232.

Cases finding no state action since *Baksalary* are numerous and, of course, "fact driven." *Mark*, 51 F.3d 1137, although it found state action, is significant to my decision in this case for at least two reasons. First, the court explained that in *Edmonson*, the Supreme Court clarified the *Lugar* joint participation test in part by describing in more detail the second prong of that test. This more detailed explanation in *Edmonson* came well after the *Baksalary* decision. Second, *Mark* involved the question as to whether the Borough and Enterprise Fire Company, a volunteer fire company, could be liable under § 1983 for damages resulting from arson committed by a member of that company. The facts which supported state action show how governmental authority can so dominate an activity that its participants must be considered state actors.

The *Mark* court initially concluded in analyzing the second factor of the *Edmonson/Lugar* criteria that the fire company did provide services which are a traditional government function. It also undertook an analysis as to the extent to which the fire company relied upon government assistance and benefits (the first *Edmonson/Lugar* factor, 500 U.S. at 620, 111 S. Ct. at 2082). It noted that numerous legislative enactments interweave the functioning of government and the fire company. Also in this particular case, the fire company had an agreement with the Borough whereby the Borough agreed to provide sufficient funds for its operation and capital expenditures by imposition of a fire tax. The fire company was designated as "the duly appointed fire

company to service the Borough of Hatboro." The fire chief was required to attend meetings of the Borough council. *Mark*, 51 F.3d at 1147.

While not using the terminology of the third *Edmonson/Lugar* factor, the court in *Mark* did explain that the alleged wrongful act (the method of electing firefighters) was directly related to the state created duty to provide fire protection in the first place. By way of contrast, the facts in a series of cases not finding state action follow.

In *Jordan v. Fox, Rothschild, O'Brien & Frankel*, 20 F.3d 1250 (3d Cir. 1994), the court found that the entry of judgment by confession did not involve state action. The court agreed with the district court that "a state procedure permitting private parties to file a complaint and confess judgment essentially involves acquiescence by the state, not compulsion. In such circumstances, private conduct is not attributable to the state." *Jordan*, 20 F.3d at 1266. Similarly, defendant insurers feel that what they do in making an independent decision to withhold payment of medical benefits and thereafter file the appropriate form "essentially involves acquiescence by the state, not compulsion."

I should note that in *Jordan*, which followed *Lugar*, the court found that when a judgment creditor uses Pennsylvania procedure for executing on a conferred judgment, he becomes a state actor. It seems clear in the line of cases dealing with confessed judgments and procedures for collection that a distinction is made between what is or is not a significant contribution by the state to the constitutional deprivation; that is, has the state by statute authorized its own officers to invoke the force of law in aid of a private person's request. *See also Tulsa Professional Collection Services, Inc. v. Pope*, 485 U.S. 478, 108 S. Ct. 1340, 99 L. Ed. 2d 565 (1988) (in which state action found because executrix not authorized to act until appointed by court under Oklahoma probate code).

Three cases since *Baksalary* seem to suggest by their ultimate conclusion that state statutes similar to the one in this case do not authorize its officers to invoke the force of law in aid of a private person's request: *Barnes v. Lehman*, 861 F.2d 1383 (5th Cir. 1988); *Grenz v. EBI/Orion Group, Inc.*, 968 F.2d 1220 (9th Cir. 1992); and *Fleming v. Workers' Compensation Commission*, 878 F. Supp. 852 (E.D. Va. 1995).

In *Barnes*, in which a worker's benefits could be stopped, by statute, based on a doctor's medical opinion, the plaintiff argued that the insurers invoked the aid of state officials when filing the forms incident to ceasing payment. But the *Barnes* court held: "Regulations that dictate procedures, forms or even penalties without dictating the challenged action do not convert private action into state action. The decision to adopt Dr. Lehman's opinion as final and to cease Barnes' benefits was a decision initiated by the insurer and not the state." *Barnes*, 861 F.2d at 1387.

The *Barnes* court, in commenting on Lugar, found that prejudgment attachment cannot be equated to a summary termination of compensation benefits without an adjudication or administrative hearing. The court went on to cite *Flagg Bros., Inc. v. Brooks*, 436 U.S. 149, 98 S. Ct. 1729, 56 L. Ed. 2d 185 (1978) for the proposition that the "total absence of overt official involvement plainly distinguishes" the actions of private entities pursuant to a self help provision of the New York Commercial Code from actions of creditors acting jointly with state officers pursuant to prejudgment attachment procedures. *Barnes*, 861 F.2d at 1387 (citing *Flagg Bros.*, 436 U.S. at 157, 98 S. Ct. at 1733).

In *Grenz*, the plaintiff argued that the state of Montana and the insurers are joint participants in the workers' compensation scheme because the state mandates workers' compensation, certifies and regulates workers' compensation insurance companies, and provides workers' compensation directly to a significant number of workers. The state itself, however, apparently has nothing to do with the panel of physicians who examine plaintiff pursuant to Montana law to determine whether he is still eligible for benefits or what the insurer does thereafter based on its findings. The Montana law does require the plaintiff to submit to the examination by the panel. If the insurer does alter the benefits, the worker may challenge the change in the Montana Workers' Compensation Court. The analysis in *Grenz* is brief. Citing *Edmonson*, the court concludes that the insurers were not state actors, even though benefits are altered or terminated prior to a hearing.

Fleming involved a Virginia statute. In that state an employee's right to compensation ceases upon her unjustified refusal to accept suitable employment. To implement this statute, the commission rules permit an insurer to suspend or modify compensation pending acceptance or rejection of an employer's application filed to allege such unjustified refusal. The court stated "USF&G is authorized, but not required, to suspend benefits. And, while the Commonwealth authorizes the challenged action, it does not dictate it. In the final analysis, the ultimate decision whether to suspend benefits rests with the insurer." *Fleming*, 878 F. Supp. at 861.

It seems clear that the later three cases decided since *Baksalary* have found the action of the private insurers in connection with state workers' compensation laws to be more analogous to the private creditor seeking judgment than to the private creditor seeking execution upon a judgment. The former involves mere acquiescence while the latter, overt state assistance. Plaintiffs suggest throughout their brief that the Bureau reviews requests for UR both for substantive and procedural compliance with the statute. The difference between the two is not clear in the context of plaintiffs' argument. One thing is clear and that is that the Bureau makes no determination as to whether the medical costs are reasonable or necessary. That, it seems to me, is the substantive matter involved in a request for UR.

In coming to the ultimate decision in this case, I find some comfort in the reference made by the court in *Groman v. Township of Manalapan*, 47 F.3d 628, 639 (3d Cir. 1995) as follows:

> We note initially that, as one commentator has observed: Imposing categories and labels on the court's different approaches to state action issues is somewhat arbitrary and potentially misleading. The court seldom describes its decisions as creating a structure of discrete state action theories. Rather, the court's decisions follow the more traditional judicial style of deciding each case based on the facts of the case, guided by similarly fact-specific decisions of the past. In addition, the court uses different phrases to refer to the same or similar theories. . . . Nonetheless, the court's state action decisions do create some clearly distinguishable

> approaches to the state action issue. Henry C. Strickland, *The State Action Doctrine and the Rehnquist Court*, 18 Hastings Const. L.Q. 587, 596-97 (1991) (citations omitted).

My analysis of one of the objects of the Constitution stated in *Edmonson*, the relevant case law and the development and refinement of it since *Baksalary*, leads me to conclude that the insurers in this case are not state actors, primarily because the decision to cease paying medical benefits is entirely up to the insurer acting independent of any state involvement whatsoever. The state takes no substantive step to promote, support or encourage the decision of the insurer; and after the decision is made, the state takes no action which influences the ultimate substantive determination as to whether benefits are payable or not. The state does not significantly assist private actors when it merely provides a remedy, albeit complete with authorized forms and regulations. The state's acceptance and routing of forms completed in accordance with its instructions, in essence, it seems to me, involves acquiescence and not compulsion on the part of the state.

B. School District Defendant.

As to the school district's motion to dismiss, the mere fact that it has obtained the services of a third party administrator to provide medical claims management service does not necessarily relieve it of responsibility for constitutional violations of that third party. (We are assuming, without having decided, that the third party administrators' use of UR violates plaintiffs' constitutional rights.) In this case, the school board has elected to fulfill its medical benefit obligations on its own rather than to secure an insurance carrier. To what extent the practices and policies of the school board both with regard to payment of medical benefits and to the role of the third party administrator in the determination thereof play a part in bringing about the challenged activity (request for UR) is not sufficiently clear for me to find as a matter of law in the school board's favor.

While the school district argues otherwise, I cannot determine on the present state of the record if it has promulgated any policy or custom, or coerced or exerted significant pressure on the third party administrator so as to compel the challenged activity. For example, the preliminary request for proposal for the claims

management service devotes a section to interaction with school officials, including a monthly review of serious cases with staff from the school district. Does this involve any policy or custom? By the same token, I cannot grant plaintiffs' motion for summary judgment as to the state action issue. More discovery is needed relative to practices and policies of the school board.

An order follows.

APPENDIX D

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

DELORES SCOTT SULLIVAN, et al., Plaintiffs,	:	CIVIL ACTION
	:	NO. 95-201
v.	:	
ROBERT BARNETT, et al., Defendants,	:	

ORDER

AND NOW, this 24th day of January, 1996, upon consideration of defendants American Manufacturers Mutual Insurance Company, Insurance Company of North America, Continental Casualty Company, USF&G Insurance Company and Zurich American Insurance Company's Motion to Dismiss Complaint (Docket No. 10), it is hereby ORDERED and DECREED that said Motion is GRANTED.

The Motions of the School District of Philadelphia to Dismiss Complaint (Docket Nos. 11, 12 and 14) are DENIED.

The plaintiffs' Motion for Partial Summary Judgment (Docket No. 25) is DENIED.

BY THE COURT:

/s/ RONALD L. BUCKWALTER, J.

APPENDIX E

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

DELORES SCOTT SULLIVAN, *et al.*, Plaintiffs,	:	CIVIL ACTION
	:	NO. 95-201
v.	:	
JOHNNY J. BUTLER, *et al.*, Defendants.	:	

MEMORANDUM

BUCKWALTER, J. November 7, 1996

I. INTRODUCTION

Plaintiffs in this putative civil rights action claim to be persons who had been receiving medical benefits pursuant to the Pennsylvania Workers' Compensation Law and who were thereafter deprived of those benefits without prior notice or an opportunity to be heard pursuant to the utilization review in Sections 306(f.1)(5) and (6) of the aforesaid law.

Presently before the Court for disposition are the Motion to Dismiss by defendants Johnny J. Butler, Richard A. Himler, Linda Kaiser, Catherine Baker Knoll and Ralph Chase ("Commonwealth Officials") and plaintiffs' response thereto. For the reasons stated below, the Commonwealth Officials' motion is granted.

II. BACKGROUND

This background is gleaned from plaintiffs' Amended Complaint and matters of record, *i.e.*, statutes, bulletins, etc.

The Pennsylvania Workers' Compensation Act of June 2, 1915, P.L. 726, as amended, 77 P.S. § 1 *et seq.* (Supp. 1993) (hereinafter referred to as "the Act"), is a statute of statewide applicability. Its purpose is to substitute a state-regulated insurance system which provides reasonable compensation to employees for

injuries arising in the course of their employment for the common law rights and liabilities of employers and employees.

The Act requires employers to obtain insurance or seek permission from the state to self-insure, so as to guarantee the availability of sufficient funds to pay eligible workers benefits pursuant to a statutory formula. Employers who do not self-insure may insure the payment of workers' compensation benefits with the Commonwealth-administered State Workers' Insurance Fund ("SWIF"), or with any other insurance company or mutual association authorized to insure such liability in the Commonwealth. The SWIF is required to insure all risks including those rejected or cancelled by private carriers.

On July 2, 1993, the Pennsylvania Legislature passed Act 44 which contained several amendments to the Pennsylvania Workers' Compensation Act. It became effective on August 31, 1993. Act 44 contains provisions, now known as Sections 306(f.1)(5) and (6), for utilization review of the reasonableness and necessity of medical treatment.[1] Pursuant to Sections 306(f.1)(5) and (6), an insurer or self-insured employer may seek utilization review of the reasonableness and necessity of current, prospective or retroactive medical treatment. To request utilization review, the employer or insurer must file a petition with the Bureau of Worker's Compensation ("Bureau") on a form which the Bureau designed and approved.

The Bureau screens all petitions for utilization review for conformity with Sections 306(f.1)(5) and (6) and assigns each petition to a Utilization Review Organization ("URO") certified by the Pennsylvania Department of Labor and Industry. If the Bureau finds that a petition is not in conformity with the relevant sections, the Bureau returns it to the petitioner with specific instructions. *Id.*

At the time of the assignment to the URO, the Bureau forwards a Notice of Assignment to the employee, the employer or insurer and the provider of the medical treatment under review. At this point, the employer or insurer may suspend payment for the

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[1] The relevant portions of these sections are quoted at length in the Court's memorandum filed on January 24, 1996.

challenged treatment. Neither the Request for Utilization Review or the Notice of Assignment specifically notify the employee that the insurer or employer may stop payment of the contested medical treatment pending the review.

During the hearing before the URO, only the medical provider may discuss the challenged treatment. The employee or his or her counsel may not testify before the URO or submit evidence supporting the employee's claim for benefits. Additionally, the Bureau does not specifically define the terms "reasonable and necessary", thus leaving the construction of the standard to be applied to the discretion of the individual URO's.

Until Act 1996-57 became effective on August 23, 1996, the party dissatisfied with the outcome of this initial utilization review would file for reconsideration with the Bureau on a form prepared by the Bureau within thirty days of the initial decision.[2] The Bureau would then review the form for compliance with the statute and assign the case to another URO.

Under this old system, if the employer requested reconsideration, the supersedeas of the employee's medical benefits remained in effect even if the employee received a favorable decision from the initial URO. Although the employee received a copy of the insurer's or employer's Request for Reconsideration and a copy of the Notice of Assignment issued by the Bureau, neither document specifically notified the employee that the employer or insurer could suspend payment of the contested medical treatment throughout the pendency of the reconsideration.

Like in the first hearing before the URO, the provider of medical services could discuss the treatment under review, but the employee or his or her counsel was not allowed to testify or to submit evidence.

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[2] Plaintiffs' claims surrounding this reconsideration step are not moot as two of the Plaintiffs sought reconsideration of the initial decisions in their cases and were unsuccessful. Therefore, Plaintiffs' claims present a live controversy. *See* Commonwealth Officials' Supplemental Brief In Support Of Motion To Dismiss at 4; Plaintiffs' Response to Commonwealth Officials' Motion to Dismiss at 3.

An employee who sought reconsideration unsuccessfully was liable for the payment of the URO's expenses. Likewise, if the employer or insurer sought reconsideration of an initial utilization review decision which was favorable to the employee, and the decision was reversed on reconsideration, the employee was liable for the payment of the URO's expenses.

Neither the Request for Reconsideration or the Notice of Assignment notified the employee that he or she would be liable for the URO's expenses if he or she did not prevail on reconsideration. Additionally, the Bureau did not fix the cost of the utilization review at the reconsideration level but left it to the discretion of the individual URO. There was no forma pauperis procedure to excuse the indigent employees from the assessment of the reconsideration fee. Finally, the URO assessed the fee against the employee as the losing party without any opportunity for the employee or his or her counsel to testify to the reasonableness and necessity of the medical treatment under review.

In the event a party was dissatisfied with the URO decision on reconsideration, he or she could file a Petition for Review with the Bureau on a form prepared by the Bureau. If the claimant prevailed on reconsideration, the supersedeas was lifted even if the employer or insurer filed a Petition for Review. If the claimant was unsuccessful, the supersedeas remained in effect.

The Bureau then reviewed all Petitions for Review for compliance with the statute and assigned the Petitions to a Workers' Compensation Judge for a *de novo* hearing. Proceedings before a Workers' Compensation Judge could extend for several months and claimants could await a decision for several months or even years.

Under Act 1996-57, the entire utilization review process is streamlined by the elimination of this reconsideration step. Therefore, after the initial URO issues its decision, a dissatisfied party may not seek reconsideration by another utilization review organization, as it could under the old system.

Instead, the party may petition for review of the initial URO decision by filing a Petition for Review with the Bureau on a form prepared by the Bureau. The Bureau then reviews all Petitions for Review for compliance with the statute and assigns the Petitions

directly to a Workers' Compensation Judge for a *de novo* hearing. If upon receipt of the notice of assignment to a URO the insurer had decided not to pay bills, it would now have to pay bills submitted for treatment if the initial URO determination concludes that the treatment reviewed was reasonable and necessary. *See Pa. Bulletin*, Vol. 26, No. 33, p. 3980 (Aug. 17, 1996).

The Bureau has promulgated no regulations setting forth how Workers' Compensation Judges are to handle Petitions for Review on the following procedures: who has the burden of proof, what evidence will be allowed, the type and extent of hearing provided, whether the utilization reviewer may testify, whether the claimant must undergo medical examination and whether the parties may take depositions.

III. DISCUSSION

A. Standard on Motion to Dismiss

The purpose of a motion to dismiss under Federal Rules of Civil Procedure 12(b)(6) is to test the legal sufficiency of a complaint. *Sturm v. Clark*, 835 F.2d 1009, 1011 (3d Cir. 1987). A complaint may be dismissed for failure to state a claim upon which relief may be granted if the facts plead and reasonable inferences therefrom are legally insufficient to support the relief requested. *Commonwealth ex. rel. Zimmerman v. PepsiCo, Inc.*, 836 F.2d 173, 179 (3d Cir. 1988). In reviewing a motion to dismiss, all allegations in the complaint and all reasonable inferences that can be drawn therefrom must be accepted as true and viewed in the light most favorable to the nonmoving party. *Wisniewski v. Johns-Manville Corp.*, 759 F.2d 271, 273 (3d Cir. 1985).

As due process is a question of law and not of fact, this is a proper question for a court decide in a motion to dismiss. *Midnight Sessions, Ltd. v. City of Philadelphia*, 945 F.2d 667, 682-83 (3d Cir. 1991), *cert. denied*, 503 U.S. 984 (1992). This is particularly appropriate in the current case as the interests at stake and the procedures at issue are evident from the Workers' Compensation Act and its regulations. *See Mathews v. Eldridge*, 424 U.S. 319, 335-340 (1976) (the court relied on the Social Security Act and its regulations in analyzing both the issues at stake and the reliability of the procedure in place).

B. Automatic Supersedeas

In Counts I and II of the Complaint, plaintiffs claim that (1) the automatic supersedeas contained in Section 306(f.1)(5) violates plaintiffs' right to procedural due process and (2) Sections 306(f.1)(5) and (6) do not provide the plaintiffs the opportunity to be heard at a meaningful time in violation of their right to procedural due process.[3]

In support of their motion to dismiss, the Commonwealth Officials make several arguments including: (1) that the due process clause does not prohibit the Commonwealth from allowing private insurers to suspend payment for medical treatments pending determination of their liability to pay for those treatments and (2) that the utilization review procedures afford employees adequate procedures regardless of whether they are invoked by private insurers or by the SWIF.

A claim under section 1983 alleging a violation of the due process clause of the Fourteenth Amendment requires proof of three elements. First, a section 1983 claimant must show a deprivation of a constitutionally protected liberty or property interest. *Baksalary v. Smith*, 579 F. Supp. 218, 224 (E.D. Pa. 1984). Second, the claimant must show that the method by which the deprivation was effectuated involved a denial of due process. *Id.* Third, the claimant must show that the deprivation was accomplished under state law and as a result of state action. *Id.* With this standard in mind, the Court will address the Commonwealth Officials' arguments separately.

1. Deprivation

As discussed in a previous portion of this opinion, the Workers' Compensation Act permits an employer or insurer to challenge the reasonableness and necessity of an employee's

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[3] In Count VI of the Complaint, plaintiffs allege that the deprivation of medical benefits authorized by Sections 306(f.1)(5) and (6) deprive Plaintiffs of liberty without due process of the law. Neither the plaintiffs or the Commonwealth Officials specifically address this claim, but the discussion of due process hereafter encompasses both the property and liberty interest.

medical treatment by submitting a request to the Bureau of Workers' Compensation. The Bureau then assigns the request to a Utilization Review Organization ("URO"). At this point, the employer or insurer may suspend payment for the challenged treatment.

Upon review, the reviewer may, of course, determine that the treatment is unreasonable and unnecessary for the medical condition of the employee. However, the reviewer may also determine that the opposite is true. If either side is then dissatisfied with the result, the party may appeal to the Bureau for a *de novo* hearing in front of a Worker's Compensation Judge.

In light of these facts, the Court must determine whether the plaintiffs are deprived of a constitutionally protected property interest when they must forgo the use of their workers' compensation medical benefits during the utilization review process. I hold that they are deprived of a constitutionally protected property interest.

This decision is supported by a long line of case law. In a similar case involving the termination of Social Security disability benefits pending a final hearing, the Supreme Court stated that it "has been implicit in our prior decisions ... that the interest of an individual in continued receipt of these benefits is a statutorily created 'property' interest...." *Mathews*, 424 U.S. at 332 (citations omitted).

More recently in *Baksalary v. Smith*, the United States District Court for the Eastern District of Pennsylvania extended *Mathews* and held that the right to receive workers' compensation benefits is also a property interest. 579 F. Supp. 218, 225 (E.D. Pa. 1984). As a result of these decisions, the Court concludes that the plaintiffs have undergone the deprivation of a constitutionally protected property interest when they are deprived even for a short time of their workers' compensation medical benefits.

2. Due Process

Having decided that the medical benefits termination under the Workers' Compensation Act must comply with the Fourteenth Amendment, the Court must now consider whether the Act accords plaintiffs sufficient process to constitute due process. *Baksalary*,

579 F. Supp. at 232 (citing *Perri v. Aytch*, 724 F.2d 362, 366 (3d Cir. 1983)). I conclude that it does.

In *Goldberg v. Kelly*, 397 U.S. 254, 266-71 (1970), the Supreme Court concluded that the respective state agencies may not terminate a claimant's welfare payments without first affording the claimant a hearing. However, in *Mathews v. Eldridge*, 424 U.S. 305 (1976), the Court declined to extend the holding in *Goldberg* to cover Social Security disability benefit claimants.

The Court in *Mathews* distinguished *Goldberg* as having been based on welfare recipients' extreme financial need and concluded that since eligibility for disability benefits is not based on need and since the beneficiaries might have other means of subsistence, the claimants were not entitled to a pre-termination hearing. *Mathews*, 424 U.S. at 340-41.

On these grounds, this case is similar to *Mathews*. As with Social Security disability benefits, an employee's eligibility for medical benefits under the Workers' Compensation Act is based on factors other than financial need. Additionally, the injured employee may have other sources of income, including the right to receive wage replacement.

Mathews sets forth the following criteria to determine if a particular system comports with due process: (1) the private interest that will be affected by the action, (2) the risk that the procedures will result in an erroneous deprivation of the interest and (3) the governmental interest, including the function involved and fiscal and administrative burdens that the additional or substitute requirement would entail. *Mathews*, 424 U.S. at 335.

a. Private Interests

Since the plaintiffs whose medical benefits are terminated receive full retroactive relief, the private interest at stake here is the plaintiffs' desire for uninterrupted receipt of this benefit pending the final administrative decision on their cases. *See Mathews*, 424 U.S. at 340 (recipients of Social Security disability benefits sole interest is in uninterrupted receipt of this source of income as full relief may be awarded).

The plaintiffs' interest in this case is without a doubt significant. However, several factors exist which protect plaintiffs' interest. First, eligibility for workers' compensation medical benefits is not based on financial need. Therefore, termination of this aid pending resolution of the controversy will not deprive the plaintiffs of the very means by which they live. *See Mathews*, 424 U.S. at 340 (citations omitted). Moreover, the plaintiffs may have access to additional income sources such as wage replacement. *See Mathews*, 424 U.S. at 341-42 (claimants may have support from many other sources, "such as earnings of other family members, workmen's compensation awards, tort claim awards, savings, private insurance, public or private pensions, veterans' benefits, food stamps, public assistance ....).[4]

Additionally, the availability of full remedies lessens the potential harm to the individual employees and therefore protects their interests. *See Cryder v. Oxendine*, 24 F.3d 175, 178 (11th Cir. 1994) (because Georgia's Workers' Compensation Act provides full retroactive relief, the potential harm to the individual employee is less).

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[4] Plaintiffs imply that these additional financial resources are inconsequential to this action because, under the unique circumstances of the Workers' Compensation Act, the provider cannot seek the payment for the challenged treatment from the employee. *Plaintiffs' Response* at 16. *See also* 77 P.S. § 531(7) (Purdon's Supp. 1996).

Although the hardship imposed on the employee whose medical benefits are erroneously suspended is significant, Plaintiffs are still not without recourse. First, nothing in the statute indicates that a claimant is prohibited from reimbursing the medical provider when the administrative process is concluded. Additionally, nothing in the statute even requires that the medical provider stop giving the challenged treatment.

When faced with similar concerns, the Court in *Mathews* still held that "[i]n view of these potential sources of temporary income [private resources and government assistance], there is less reason here than in *Goldberg* to depart from our ordinary principle, established by our decisions, that something less than an evidentiary hearing is sufficient prior to adverse administrative action." 424 U.S. at 343.

In this case, the injured employee has the benefit of the following remedies. An employee, who appeals from an adverse URO decision and then prevails before a Workers' Compensation Judge, is entitled to an award of benefits due plus 10% interest. 77 P.S. § 717.1(a) (Purdon's Supp. 1996). Additionally, the prevailing employee at this level may also recover the costs of the litigation. 77 P.S. § 996 (Purdon's Supp. 1996). I do not wish to deprecate the employee's interest in the timely receipt of medical benefits, but when considering the nature of that interest as described in this memorandum, I believe it is adequately protected by the procedures in place. That is, a full evidentiary hearing prior to a possible temporary suspension of benefits is not an indispensable requisite for the process that is due, for reasons that follow in "b."

b. Risk of Erroneous Deprivation

The plaintiffs contend that they are not given adequate notice that their medical benefits will be suspended through the utilization review process and are not provided with an opportunity to be heard at a meaningful time in a meaningful manner, thereby resulting in the risk of erroneous deprivation. The plaintiffs specifically argue that their due process rights are violated because they are not entitled to present evidence directly to the reviewers at the first step in the process.

In *Mathews*, the claimant had the benefit of the following procedures:

> [w]henever the agency's tentative assessment of the beneficiary's condition differs from his own assessment, the beneficiary is informed that benefits may be terminated, provided a summary of the evidence upon which the proposed determination to terminate is based and afforded an opportunity to review the medical reports and other evidence in his case file. He may also respond in writing and submit additional evidence.

424 U.S. at 337-38.

With these procedures in mind, the Supreme Court concluded that disability insurance recipients threatened with a loss of benefits were accorded a sufficient pretermination process, even though that process did not include a formal evidentiary hearing, so that an

evidentiary hearing could be postponed until after termination. The procedures upheld in *Mathews* were regarded by the Court as "provid[ing] the claimant with an effective process of asserting his claim prior to any administrative action...." 424 U.S. at 349.

The Pennsylvania Workers' Compensation Act also provides these necessary safeguards to guard against the risk of erroneous deprivation. First, the risk of error is minimal because the URO's decision must be based on a medical determination. The Supreme Court has characterized medical reports as "routine, standard and unbiased." *Richardson v. Perales*, 402 U.S. 389, 407 (1971). The Court also recognized the "reliability and probative worth of written medical reports," emphasizing that while there may be "professional disagreement with the medical conclusions" the "specter of questionable credibility and veracity is not present." *Id.*

Second, as only the injured employee's treating physician may testify before the URO and the URO may only base its decision on this physician's testimony and records, the risk of an erroneous decision becomes even more minimal. In *Mathews*, the disability claimants were not even afforded the benefit of their own medical provider's testimony, as the government could seek its own independent medical examination and decide to terminate benefits on the basis of that physician's report. *Id.* at 337-38. With these guidelines in place, the potential value of an evidentiary hearing is slight.

The decision in *Baksalary* does not require a different conclusion. In *Baksalary*, plaintiffs challenged the constitutionality of the former section 413 of the Workers' Compensation Act, which permitted an automatic supersedeas of *all* benefits. *Baksalary*, 579 F. Supp. at 220. The supersedeas took effect when the employer or insurer filed a petition that alleged either that (1) the employee returned to work at the same or greater rate of pay or (2) the employee had completely recovered. *Id.* at 221. To be entitled to a supersedeas on the second ground, the petition had to be accompanied by an affidavit of a physician based on an examination made within fifteen days of the filing of the petition. *Id.*

The court in *Baksalary* concluded that the procedure violated due process because the employee was not given prior notice of the

suspension nor an opportunity to respond to the doctor's affidavit. *Id.* at 232-33. The court in the concurring opinion also found that the procedure was flawed because of the notice defect and the insufficient guarantee of decisionmaker impartiality. *Id.* at 236-237. These flaws are not present under the current Workers' Compensation Act.

First, the utilization review procedure is much narrower and incorporates more procedural protection than the old automatic supersedeas provision. Under the current system, only payments for specified medical treatment are subject to utilization review and the accompanying suspension of payment as opposed to all benefits - wage replacement as well as medical.

Additionally, the utilization review itself is extremely focused. First, a person licensed in the same profession and having the same or similar specialty as the medical provider must conduct the review. 34 Pa. Code § 127.466. Additionally, the reviewer may only apply generally accepted treatment protocols to the case. 34 Pa. Code § 127.647.

Based on the application of these protocols, the reviewer must then decide whether the particular treatment is reasonable and necessary for only the medical condition at issue. 34 Pa. Code § 127.470. Reviewers must assume that the condition being treated is related to a work injury. *Id.* They must also refrain from deciding whether an employee is still disabled, whether the employee has obtained maximum medical improvement or whether the fees charged are reasonable. *Id.*

Second, as discussed above, the URO reviewer is only permitted to consider the treating provider's records and testimony in making a decision, thereby ensuring more decisionmaker impartiality. In contrast, the employers or insurers submitted affidavits from physicians of their own choosing under the old provisions.

Third, the current Act provides the plaintiffs with adequate notice regarding the suspension of benefits through the conclusion of the review process. Under the Act, the Bureau is required to serve the employer's or insurer's Request for Review of specific treatment on all parties. 34 Pa. Code §§ 127.451, 127.452. While

this request does not specifically mention that the employee's benefits will be suspended, it does put the employee on notice of the upcoming proceedings.

In actuality, the Bureau may be unable to notify the employee that his or her benefits will be suspended. The statute does not require that the employer or insurer suspend the payment of the employee's medical bills following a Request for Review; it merely authorizes it. *See* 34 Pa. Code § 127.208 ("[t]he insurer's right to suspend payment....") As the suspension is at the employer's or insurer's discretion, the Bureau provides the employee with the information it has available.

Other jurisdictions have found that provisions which provide employees with this minimal notice are sufficient. In *Cryder v. Oxendine*, 24 F.3d at 178, the court upheld a provision in which the employer or insurer must notify the employee of termination only ten days in advance.[5] Similarly, in *Sauceda v. Department of Labor & Indus.*, 917 F.2d 1216, 1217 (9th Cir. 1990), the court concluded that the Department of Labor only had to provide a claimant with notice indicating its decision and its reasons for the decision and inform the claimant of his right to request reconsideration.[6]

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[5] In *Cryder*, 24 F.3d at 176-77, the plaintiff contended that the Georgia Workers' Compensation Act violated the Due Process Clause because the ten-day notice of impending termination and its post-termination hearing procedures were constitutionally insufficient to satisfy the requirements of due process. Under the rule in question, the employer or insurer could terminate an employee's benefits without a prior evidentiary hearing in instances where the employee had returned to work without a reduction in compensation or where the employee's authorized treating physician released the employee to normal work duty. *Id.* at 177.

[6] In *Sauceda*, the plaintiffs argued that a procedure under which the Department of Labor could suspend employment disability benefits if the claimant refused to submit to medical exams and to participate in vocational evaluation programs violated due process. *Sauceda*, 917 F.2d at 1217.

Finally, before the denial of benefits is final, the claimant is entitled to receive a full evidentiary hearing through the *de novo* hearing required upon filing of a Petition for Review.

c. Governmental Interest

The governmental and societal interest present in this case is ensuring that medical benefits are paid only to the employees who are actually disabled. Plaintiffs argue that this requires a consideration of fiscal and administrative burdens and thus cannot be decided on a motion of dismiss.

It is correct that the present record before us does not reflect the precise high costs of worker's compensation with respect to medical treatment and review and just exactly how this legislation will influence those matters in the future. Nevertheless, it is clear that this legislation was enacted in response to high costs of medical treatment, the corresponding high cost of insurance and the need to somehow bring these costs under control.

In *Mathews*, the Court did not rely on the parties' estimates of the additional financial costs but instead held that "[n]o one can predict the extent of the increase, but the fact that full benefits would continue until after such hearings would assure the exhaustion in most cases of this attractive option." *Mathews*, 424 U.S. at 347. Additionally, the Court determined that financial cost alone was not a controlling weight but that the Government's interest in "conserving scarce fiscal and administrative resources is a factor that must be weighed." *Id.* at 348. These same concerns are present in this case as well.[7]

3. State Action

In a memorandum filed on January 24, 1996, the Court dismissed the private insurers from the current action after concluding that they were not state actors. The Commonwealth Officials now argue that the privately insured plaintiffs have no claim against them for the withholding of their medical benefits as

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[7] *Mathews* at 349 also instructs us that "the judicial model of an evidentiary hearing is neither a required, nor even the most effective, method of decision making in all circumstances."

that deprivation was carried out by private actors. In light of the Court's decision that the Workers' Compensation Act comports with due process, it is unnecessary to address this argument further.

C. The Reconsideration Costs

In Count III in the Complaint, the plaintiffs assert that the assessment of a fee upon reconsideration review (no longer applicable under existing law) violates the plaintiffs' right to procedural due process.[8] I conclude that the imposition of this fee did not violate due process.

Before Act 1996-57, if either the employee or the employer or insurer was dissatisfied with the initial URO decision, that party could petition the Bureau for reconsideration within thirty days of receiving the decision.[9] However, unlike in the initial review, the Bureau would bill the losing party for the cost of this reconsideration hearing.

The Supreme Court has recognized that the imposition of filing fees can violate the Fourteenth Amendment. *See Boddie v. Connecticut*, 401 U.S. 371 (1971) (mandatory filing fees in divorce cases violate due process since they effectively denied the indigent parties the right to be heard); *Little v. Streater*, 452 U.S. 1 (1981) (imposition of costs of blood tests on an indigent party contesting a paternity suit violates due process).

However, the Supreme Court has upheld financial barriers in cases where it deemed that the plaintiffs had no fundamental right at stake. *See United States* v. *Kras*, 409 U.S. 434 (1973) (payment

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[8] In Count IV of the Complaint, the Plaintiffs allege that the assessment of a fee upon reconsideration review violates their right to substantive due process. Neither party addresses this issue and no basis for it appears in the complaint.

[9] As stated earlier, Act 1996-57 eliminates the reconsideration step. Act 1996-57, § 4, *amending*, Act of June 2, 1915 (P.L. 376, No. 338), § 306(f.1)(6). After the URO issues its initial decision, a dissatisfied party need not seek reconsideration through another URO. *Id.* Instead, the party may petition for review of the decision through a *de novo* hearing before a Workers' Compensation Judge. *Id.*

of filing fees as condition precedent to obtaining discharge in bankruptcy does not violate due process); *Ortwein v. Schwab*, 410 U.S. 656 (1973) (appellate filing fee as applied to indigents seeking to appeal an adverse welfare is not violative of due process).

In this case, the interest at issue is plaintiffs' desire for uninterrupted receipt of their workers' compensation medical benefits. This interest is more akin to the plaintiffs' interests in *Kras* and *Ortwein*. While these interests are important, they simply do not command the same deference as the other rights which the Supreme Court has deemed to be fundamental. *See Bullock v. Carter*, 405 U.S. 134 (1972) (right to vote); *Williams v. Rhodes*, 393 U.S. 23 (1968) (freedom of association); *Shapiro v. Thompson*, 394 U.S. 618 (1969) (right to travel); *Skinner v. Oklahoma ex rel. Williamson*, 316 U.S. 535 (1942) (right to procreate).

However, as the plaintiffs correctly assert, both *Boddie* and its progeny do not turn exclusively on the nature of the interest that the plaintiff sought to vindicate. *See Lecates v. Justice of the Peace Court No. 4*, 637 F.2d 898, 908 (3d Cir. 1980). The Supreme Court has also stressed the existence of alternatives to the judicial remedies which are not conditioned on the payment of fees. *See Kras*, 410 U.S. at 446.

In *Ortwein v. Schwab*, the plaintiffs argued that an Oregon appellate filing fee, which indigents seeking to appeal an adverse welfare decision had to pay, violated the due process clause of the Fourteenth Amendment. 410 U.S. 656, 658 (1973). The Supreme Court first determined that the indigents had hearings and that those hearings provided "a procedure, not conditioned on payment of any fee, through which [the indigents] have been able to seek redress." *Ortwein*, 410 U.S. at 659-60. The Court then held that "[t]his Court has longed recognized that, even in criminal cases, due process does not require a State to provide an appellate system." *Id.* at 660.

Likewise, these plaintiffs have an alternative to the judicial remedies not conditioned on the payment of fees as the expenses for the initial URO hearing are borne by the employer or insurer. *See* 77 P.S. § 531(6)(iii) (Purdon's Supp. 1996). As is also required, this hearing meets the minimal requirements of due process. *See*

Ortwein, 410 U.S. at 660 n.4 (evidentiary hearings must meet the minimal requirements of due process).

Plaintiffs however argue that *Ortwein* and *Kras* are still inapposite to this case because those cases concern challenges by persons seeking to initiate a judicial process. In support of their argument, the plaintiffs cite *Lecates v. Justice of the Peace Court No. 4*, 637 F.2d at 908 for the proposition that these factors (the nature of the interest involved and the alternatives to judicial remedies) are irrelevant when a defendant is brought into court against his or her will.

In *Lecates*, the plaintiff argued that a nonwaivable bond requirement operated to deny indigents due process of the law. 637 F.2d at 900. Under the two-tier trial court system in Delaware, a plaintiff who was unsuccessful before the justice of the peace court (the first tier) was entitled to a trial *de novo* in Superior Court (the second tier). *Id.* The losing defendant in the justice of peace court, however, had to first post a surety bond in order to obtain such a trial. *Id.* The value of the surety bond had to be equal to the amount of judgment plus costs, but could be higher at the discretion of the magistrate. *Id.* at 901.

In determining that this surety bond requirement violated due process, the Third Circuit Court of Appeals first determined that "persons forced to settle their claims of right and duty through the judicial process must be given a meaningful opportunity to be heard." *Lecates*, 637 F.2d at 909 (citing *Brodie*, 401 U.S. at 377). Therefore, as the court held that the right to receive a trial *de novo* in Superior Court was a constitutional requirement, the court concluded that "Delaware may not, consonant with due process, make a defendant's opportunity to enjoy the right dependant on the amount of money he has." *Id.*

In contrast, the plaintiffs' right to a reconsideration hearing is not dependant on the amount of money he or she has. As the Bureau advances the costs of reconsideration, an employee, unlike the plaintiff in *Lecates*, is not denied access to the appellate system, or in this case, reconsideration by another URO. 34 Pa. Code § 127.514(9)(a).

Additionally, any party dissatisfied with the decision on reconsideration may then seek further review by filing another petition with the Bureau. 77 P.S. § 531(6)(iv) (Purdon's Supp. 1995). The Bureau then assigns the petition to a Workers' Compensation Judge for a *de novo* hearing. Not only is there no cost for this hearing, but the employee may recover the cost of the litigation at this level if he or she prevails. 77 P.S. § 996 (Purdon's Supp. 1996). Therefore, even under *Lecates*, the assessment of the fee does not violate due process.

D. The Regulations

In Count V of the Complaint, the plaintiffs allege that the lack of regulations governing procedures before Workers' Compensation Judges reviewing URO decisions violates the plaintiffs' rights to procedural due process. Specifically, the plaintiffs argue that the regulations promulgated by the Bureau fail to provide any standard for determining whether a challenged treatment is "reasonable and necessary" and provide no guidance as to how petitions for review are to be litigated before Workers' Compensation Judges. I conclude that the Bureau has promulgated sufficient regulations and provided adequate guidance to the Workers' Compensation Judges.

The establishment of "written, objective, and ascertainable standards is an elementary and intrinsic part of due process." *Baker-Chaput v. Cammett*, 406 F. Supp. 1134, 1140 (D.N.H. 1976). Without these standards, the underlying purpose of providing due process in the first place — to reduce the risk of error through arbitrary decisionmaking — cannot be met. *Carey v. Quern*, 588 F.2d 230, 232 (7th Cir. 1978). A system without such standards and which vests unfettered discretion in the decisionmaker violates due process. *White v. Roughton*, 530 F.2d 750, 754 (7th Cir. 1976).

In this case, the regulations at issue provide more than enough guidance to the doctors and other health care providers who conduct the utilization review. Although these regulations do not specifically define the standard of "reasonable and necessary" medical treatment, they provide the reviewer with ample guidance on how to approach this question.

For example, under the regulations, the reviewer must base his or her decision on generally accepted treatment protocols and appropriate medical literature. 34 Pa. Code § 127.472. Additionally, the reviewer is limited in his or her inquiry and may not consider whether the injury is work-related, whether the employee is still disabled, whether the employee has reached maximum medical improvement or whether the provider's fees are reasonable. 34 Pa. Code § 127.470.

Not only do these regulations provide the reviewer with guidance, the regulations also serve the equally necessary function of limiting the discretionary power of the reviewer. *See White*, 530 F.2d at 754 (administrator's procedure of allowing staff to determine eligibility for assistance grants based on their own unwritten standards was violative of due process); *Moe v. Brookings County*, 659 F.2d 880, 883 (8th Cir. 1981) (system which gives county commissioner complete discretion in determining the availability of assistance violated due process). As the reviewer must abide by the guidelines described above and must furnish the parties with a detailed written opinion, the reviewer's authority is appropriately curtailed. *See* 34 Pa. Code § 127.472.

Second, the Bureau has also provided the Workers' Compensation Judges with adequate guidance. First, these Judges have the benefit of a *de novo* hearing. As they are adjudicators in this adversarial proceeding, they hear testimony and must make decisions within the framework of the evidence, the statute and the case law. Additionally, the regulations provide that the Judges shall consider the utilization report as evidence but shall not be bound by the report. Act 1996-57, § 4, *amending*, Act of June 2, 1915 (P.L. 376, No. 338), § 306(f.1)(6)(iv). As these Judges do not have complete discretion, the lack of uniformity in judicial decisions by itself does not violate due process. *See Bishop v. Mazurkiewicz*, 634 F.2d 724, 726 (3d Cir. 1980), *cert. denied*, 452 U.S. 917 (1981).

IV. CONCLUSION

For the above reasons, Commonwealth Officials' motion to dismiss the amended complaint is granted.

An order follows.

APPENDIX F

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

DELORES SCOTT SULLIVAN, *et al.*, Plaintiffs,	:	CIVIL ACTION
	:	NO. 95-201
v.	:	
JOHNNY J. BUTLER, *et al.*, Defendants.	:	

ORDER

AND NOW, this 7th day of November, 1996, upon consideration of Defendants' Motion to Dismiss Plaintiffs' Amended Complaint (Docket No. 45), and plaintiffs' response thereto, it is hereby ORDERED that said Motion is GRANTED, and the Amended Complaint is DISMISSED as to defendants Johnny J. Butler, the Secretary of Labor and Industry for the Commonwealth of Pennsylvania, Richard A. Himler, the Director of the Bureau of Workers' Compensation, Linda Kaiser, the Insurance Commissioner, Catherine Baker Knoll, the State Treasurer, and Ralph Chase, the Director of the State Workmen's Insurance Fund, ("Commonwealth Officials").

BY THE COURT:

/s/
RONALD L. BUCKWALTER, J.

APPENDIX G

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

DELORES SCOTT SULLIVAN, et al., Plaintiffs	:	CIVIL ACTION NO. 95-CV-201
v.	:	
JOHNNY J. BUTLER, et al., Defendants	:	

ORDER

AND NOW, this 13 day of December, 1996, upon consideration of the School District of Philadelphia's Motion for Judgment on Plaintiffs' Amended Complaint, it is hereby ORDERED and DECREED that said Motion is GRANTED and the Amended Complaint is DISMISSED as to defendant School District of Philadelphia.

BY THE COURT:

/s/
RONALD L. BUCKWALTER, J.

APPENDIX H

STATUTES AND REGULATIONS INVOLVED

77 Pa. Stat. Ann. § 29. Definitions.

In addition to the definitions set forth in this article, the following words and phrases when used in this act shall have the meanings given to them in this section unless the context clearly indicates otherwise:

* * *

"Health care provider" means any person, corporation, facility or institution licensed or otherwise authorized by the Commonwealth to provide health care services, including, but not limited to, any physician, coordinated care organization, hospital, health care facility, dentist, nurse, optometrist, podiatrist, physical therapist, psychologist, chiropractor or pharmacist and an officer, employee or agent of such person acting in the course and scope of employment or agency related to health care services.

* * *

"Utilization review organizations" shall be those organizations consisting of an impartial physician, surgeon or other health care provider or a panel of such professionals and providers as authorized by the Secretary of Labor and Industry and published as a list in the form of a notice in the Pennsylvania Bulletin for the purpose of reviewing the reasonableness and necessity of treatment by a health care provider pursuant to section 306(f.1)(6).

77 Pa. Stat. Ann. § 481. Exclusiveness of remedy; actions by and against third party; contract indemnifying third party.

(a) The liability of an employer under this act shall be exclusive and in place of any and all other liability to such employes, his legal representative, husband or wife, parents,

dependents, next of kin or anyone otherwise entitled to damages in any action at law or otherwise on account of any injury or death as defined in section 301(c)(1) and (2) or occupational disease as defined in section 108.

(b) In the event injury or death to an employe is caused by a third party, then such employe, his legal representative, husband or wife, parents, dependents, next of kin, and anyone otherwise entitled to receive damages by reason thereof, may bring their action at law against such third party, but the employer, his insurance carrier, their servants and agents, employes, representatives acting on their behalf or at their request shall not be liable to a third party for damages, contribution, or indemnity in any action at law, or otherwise, unless liability for such damages, contributions or indemnity shall be expressly provided for in a written contract entered into by the party alleged to be liable prior to the date of the occurrence which gave rise to the action.

77 Pa. Stat. Ann. § 501. Insurance of payment of compensation by employer; appeal from denial of exemption; effect of failure to insure; penalty; remedies for failure to secure payment.

(a)(1) Every employer liable under this act to pay compensation shall insure the payment of compensation in the State Workmen's Insurance Fund, or in any insurance company, or mutual association or company, authorized to insure such liability in this Commonwealth, unless such employer shall be exempted by the department from such insurance. Such insurer shall assume the employer's liability hereunder and shall be entitled to all of the employer's immunities and protection hereunder except, that whenever any employer shall have purchased insurance to provide benefits under this act to persons engaged in domestic service, neither the employer nor the insurer may invoke the provisions of section 321 as a defense. An employer desiring to be exempt from insuring the whole or any part of his liability for compensation shall make application to the department, showing his financial ability to pay such compensation,

whereupon the department, if satisfied of the applicant's financial ability, shall, upon the payment of a fee of five hundred dollars ($500), issue to the applicant a permit authorizing such exemption.

* * *

77 Pa. Stat. Ann. § 531. Surgical and medical services and supplies; designation by employer; artificial limb or eye.

(1)(i) The employer shall provide payment in accordance with this section for reasonable surgical and medical services, services rendered by physicians or other health care providers, including an additional opinion when invasive surgery may be necessary, medicines and supplies, as and when needed. Provided an employer establishes a list of at least six designated health care providers, no more than four of whom may be a coordinated care organization and no fewer than three of whom shall be physicians, the employe shall be required to visit one of the physicians or other health care providers so designated and shall continue to visit the same or another designated physician or health care provider for a period of ninety (90) days from the date of the first visit: Provided, however, That the employer shall not include on the list a physician or other health care provider who is employed, owned or controlled by the employer or the employer's insurer unless employment, ownership or control is disclosed on the list. Should invasive surgery for an employe be prescribed by a physician or other health care provider so designated by the employer, the employe shall be permitted to receive an additional opinion from any health care provider of the employe's own choice. If the additional opinion differs from the opinion provided by the physician or health care provider so designated by the employer, the employe shall determine which course of treatment to follow: Provided, That the second opinion provides a specific and detailed course of treatment. If the employe chooses to follow the procedures designated in the second opinion, such procedures shall be performed by one of the physicians or other health care providers so designated by the employer for a period of ninety

(90) days from the date of the visit to the physician or other health care provider of the employe's own choice. Should the employe not comply with the foregoing, the employer will be relieved from liability for the payment for the services rendered during such applicable period. It shall be the duty of the employer to provide a clearly written notification of the employe's rights and duties under this section to the employe. The employer shall further ensure that the employe has been informed and that he understands these rights and duties. This duty shall be evidenced only by the employe's written acknowledgment of having been informed and having understood his rights and duties. Any failure of the employer to provide and evidence such notification shall relieve the employe from any notification duty owed, notwithstanding any provision of this act to the contrary, and the employer shall remain liable for all rendered treatment. Subsequent treatment may be provided by any health care provider of the employe's own choice. Any employe who, next following termination of the applicable period, is provided treatment from a nondesignated health care provider shall notify the employer within five (5) days of the first visit to said health care provider. Failure to so notify the employer will relieve the employer from liability for the payment for the services rendered prior to appropriate notice if such services are determined pursuant to paragraph (6) to have been unreasonable or unnecessary.

(ii) In addition to the above service, the employer shall provide payment for medicines and supplies, hospital treatment, services and supplies and orthopedic appliances, and prostheses in accordance with this section. Whenever an employe shall have suffered the loss of a limb, part of a limb, or an eye, the employer shall also provide for an artificial limb or eye or other prostheses of a type and kind recommended by the doctor attending such employe in connection with such injury and any replacements for an artificial limb or eye which the employe may require at any time thereafter, together with such continued medical care as may be prescribed by the doctor attending such employe in connection with such injury as well as such training as may be required in the proper use

of such prostheses. The provisions of this section shall apply to injuries whether or not loss of earning power occurs. If hospital confinement is required, the employe shall be entitled to semiprivate accommodations, but, if no such facilities are available, regardless of the patient's condition, the employer, not the patient, shall be liable for the additional costs for the facilities in a private room.

(iii) Nothing in this section shall prohibit an insurer or an employer from contracting with any individual, partnership, association or corporation to provide case management and coordination of services with regard to injured employes.

(2) Any provider who treats an injured employe shall be required to file periodic reports with the employer on a form prescribed by the department which shall include, where pertinent, history, diagnosis, treatment, prognosis and physical findings. The report shall be filed within ten (10) days of commencing treatment and at least once a month thereafter as long as treatment continues. The employer shall not be liable to pay for such treatment until a report has been filed.

(3)(i) For purposes of this clause, a provider shall not require, request or accept payment for the treatment, accommodations, products or services in excess of one hundred thirteen per centum of the prevailing charge at the seventy-fifth percentile; one hundred thirteen per centum of the applicable fee schedule, the recommended fee or the inflation index charge; one hundred thirteen per centum of the DRG payment plus pass-through costs and applicable cost or day outliers; or one hundred thirteen per centum of any other Medicare reimbursement mechanism, as determined by the Medicare carrier or intermediary, whichever pertains to the specialty service involved, determined to be applicable in this Commonwealth under the Medicare program for comparable services rendered. If the commissioner determines that an allowance for a particular provider group or service under the Medicare program is not reasonable, it may adopt, by regulation, a new allowance. If the prevailing charge, fee schedule, recommended fee, inflation index charge, DRG

payment or any other reimbursement has not been calculated under the Medicare program for a particular treatment, accommodation, product or service, the amount of the payment may not exceed eighty per centum of the charge most often made by providers of similar training, experience and licensure for a specific treatment, accommodation, product or service in the geographic area where the treatment, accommodation, product or service is provided.

(ii) Commencing on January 1, 1995, the maximum allowance for a health care service covered by subparagraph (i) shall be updated as of the first day of January of each year. The update, which shall be applied to all services performed after January 1 of each year, shall be equal to the percentage change in the Statewide average weekly wage. Such updates shall be cumulative.

(iii) Notwithstanding any other provision of law, it is unlawful for a provider to refer a person for laboratory, physical therapy, rehabilitation, chiropractic, radiation oncology, psychometric, home infusion therapy or diagnostic imaging, goods or services pursuant to this section if the provider has a financial interest with the person or in the entity that receives the referral. It is unlawful for a provider to enter into an arrangement or scheme such as a cross-referral arrangement, which the provider knows or should know has a principal purpose of assuring referrals by the provider to a particular entity which, if the provider directly made referrals to such entity, would be in violation of this section. No claim for payment shall be presented by an entity to any individual, third-party payer or other entity for a service furnished pursuant to a referral prohibited under this section.

(iv) The secretary shall retain the services of an independent consulting firm to perform an annual accessibility study of health care provided under this act. The study shall include information as to whether there is adequate access to quality health care and products for injured workers and a review of the information that is provided. If the secretary determines based on this study that as a result of the health

care fee schedule there is not sufficient access to quality health care or products for persons suffering injuries covered by this act, the secretary may recommend to the commissioner the adoption of regulations providing for a new allowance.

(v) An allowance shall be reviewed for reasonableness whenever the commissioner determines that the use of the allowance would result in payments more than ten per centum lower than the average level of reimbursement the provider would receive from coordinated care insurers, including those entities subject to the act of December 29, 1972 (P.L. 1701, No. 364), known as the "Health Maintenance Organization Act," and those entities known as preferred provider organizations which are subject to section 630 of the Insurance Company Law of 1921 for like treatments, accommodations, products or services. In making this determination, the commissioner shall consider the extent to which allowances applicable to other providers under this section deviate from the reimbursement such providers would receive from coordinated care insurers. Any information received as a result of this subparagraph shall be confidential.

(vi) The reimbursement for prescription drugs and professional pharmaceutical services shall be limited to one hundred ten per centum of the average wholesale price of the product.

(vii) The applicable Medicare fee schedule shall include fees associated with all permissible procedure codes. If the Medicare fee schedule also includes a larger grouping of procedure codes and corresponding charges than are specifically reimbursed by Medicare, a provider may use these codes, and corresponding charges shall be paid by insurers or employers. If a Medicare code exists for application to a specific provider specialty, that code shall be used.

(viii) A provider shall not fragment or unbundle charges imposed for specific care except as consistent with Medicare. Changes to a provider's codes by an insurer shall be made only as consistent with Medicare and when the insurer has

sufficient information to make the changes and following consultation with the provider.

(4) Nothing in this act shall prohibit the self-insured employer, employer or insurer from contracting with a coordinated care organization for reimbursement levels different from those identified above.

(5) The employer or insurer shall make payment and providers shall submit bills and records in accordance with the provisions of this section. All payments to providers for treatment provided pursuant to this act shall be made within thirty (30) days of receipt of such bills and records unless the employer or insurer disputes the reasonableness or necessity of the treatment provided pursuant to paragraph (6). The nonpayment to providers within thirty (30) days for treatment for which a bill and records have been submitted shall only apply to that particular treatment or portion thereof in dispute; payment must be made timely for any treatment or portion thereof not in dispute. A provider who has submitted the reports and bills required by this section and who disputes the amount or timeliness of the payment from the employer or insurer shall file an application for fee review with the department no more than thirty (30) days following notification of a disputed treatment or ninety (90) days following the original billing date of treatment. If the insurer disputes the reasonableness and necessity of the treatment pursuant to paragraph (6), the period for filing an application for fee review shall be tolled as long as the insurer has the right to suspend payment to the provider pursuant to the provisions of this paragraph. Within thirty (30) days of the filing of such an application, the department shall render an administrative decision.

(6) Except in those cases in which a workers' compensation judge asks for an opinion from peer review under section 420, disputes as to reasonableness or necessity of treatment by a health care provider shall be resolved in accordance with the following provisions:

(i) The reasonableness or necessity of all treatment provided by a health care provider under this act may be subject to prospective, concurrent or retrospective utilization review at the request of an employe, employer or insurer. The department shall authorize utilization review organizations to perform utilization review under this act. Utilization review of all treatment rendered by a health care provider shall be performed by a provider licensed in the same profession and having the same or similar specialty as that of the provider of the treatment under review. Organizations not authorized by the department may not engage in such utilization review.

(ii) The utilization review organization shall issue a written report of its findings and conclusions within thirty (30) days of a request.

(iii) The employer or the insurer shall pay the cost of the utilization review.

(iv) If the provider, employer employe or insurer disagrees with the finding of the utilization review organization, a petition for review by the department must be filed within thirty (30) days after receipt of the report. The department shall assign the petition to a workers' compensation judge for a hearing or for an informal conference under section 402.1. The utilization review report shall be part of the record before the workers' compensation judge. The workers' compensation judge shall consider the utilization review report as evidence but shall not be bound by the report.

(7) A provider shall not hold an employe liable for costs related to care or service rendered in connection with a compensable injury under this act. A provider shall not bill or otherwise attempt to recover from the employe the difference between the provider's charge and the amount paid by the employer or the insurer.

(8) If the employe shall refuse reasonable services of health care providers, surgical, medical and hospital services,

treatment, medicines and supplies, he shall forfeit all rights to compensation for any injury or increase in his incapacity shown to have resulted from such refusal.

(9) The payment by an insurer or employer for any medical, surgical or hospital services or supplies after any statute of limitations provided for in this act shall have expired shall not act to reopen or revive the compensation rights for purposes of such limitations.

(10) If acute care is provided in an acute care facility to a patient with an immediately life threatening or urgent injury by a Level I or Level II trauma center accredited by the Pennsylvania Trauma Systems Foundation under the act of July 3, 1985 (P.L. 164, No. 45), known as the "Emergency Medical Services Act," or to a burn injury patient by a burn facility which meets all the service standards of the American Burn Association, or if basic or advanced life support services, as defined and licensed under the "Emergency Medical Services Act," are provided, the amount of payment shall be the usual and customary charge.

77 Pa. Stat. Ann. § 717.1. Prompt payment of compensation; interest; credit for excess payment; controversion.

(a) The employer and insurer shall promptly investigate each injury reported or known to the employer and shall proceed promptly to commence the payment of compensation due either pursuant to an agreement upon the compensation payable or a notice of compensation payable as provided in section 407 or pursuant to a notice of temporary compensation payable as set forth in subsection (d), on forms prescribed by the department and furnished by the insurer. The first installment of compensation shall be paid not later than the twenty-first day after the employer has notice or knowledge of the employe's disability. Interest shall accrue on all due and unpaid compensation at the rate of ten per centum per annum. Any payment of compensation prior or subsequent to an agreement or notice of compensation payable or a notice of temporary compensation payable or greater in amount than

provided therein shall, to the extent of the amount of such payment or payments, discharge the liability of the employer with respect to such case.

* * *

77 Pa. Stat. Ann. § 996. Contested cases regarding liability; attorney's fees and other costs; limitations and calculation.

(a) In any contested case where the insurer has contested liability in whole or in part, including contested cases involving petitions to terminate, reinstate, increase, reduce or otherwise modify compensation awards, agreements or other payment arrangements or to set aside final receipts, the employe or his dependent, as the case may be, in whose favor the matter at issue has been finally determined in whole or in part shall be awarded, in addition to the award for compensation, a reasonable sum for costs incurred for attorney's fees, witnesses, necessary medical examination, and the value of unreimbursed lost time to attend the proceedings: Provided, That cost for attorney fees may be excluded when a reasonable basis for the contest has been established by the employer or the insurer.

(b) If counsel fees are awarded and assessed against the insurer or employer, then the workers' compensation judge must make a finding as to the amount and the length of time for which such counsel fee is payable based upon the complexity of the factual and legal issues involved, the skill required, the duration of the proceedings and the time and effort required and actually expended. If the insurer has paid or tendered payment of compensation and the controversy relates to the amount of compensation due, costs for attorney's fee shall be based only on the difference between the final award of compensation and the compensation paid or tendered by the insurer.

77 Pa. Stat. Ann. § 999. Denial of supersedeas, reimbursement; appeal; workmen's compensation supersedeas fund created; assessments, notice, objections and findings; department's records; evidence; disbursements.

(a) If, in any case in which a supersedeas has been requested and denied under the provisions of section 413 or section 430, payments of compensation are made as a result thereof and upon the final outcome of the proceedings, it is determined that such compensation was not, in fact, payable, the insurer who has made such payments shall be reimbursed therefor. Application for reimbursement shall be made to the department on forms prescribed by the department and furnished by the insurer. Applications may be assigned to a workmen's compensation referee for a hearing and determination of eligibility for reimbursement pursuant to this act. An appeal shall lie in the manner and on the grounds provided in section 423 of this act, from any allowance or disallowance of reimbursement under this section.

(b) There is hereby established a special fund in the State Treasury, separate and apart from all other public moneys or funds of this Commonwealth, to be known as the Workmen's Compensation Supersedeas Fund. The purpose of this fund shall be to provide moneys for payments pursuant to subsection (a), to include reimbursement to the Commonwealth for any such payments made from general revenues. The department shall be charged with the maintenance and conservation of this fund. The fund shall be maintained by annual assessments on insurers and self-insurers under this act, including the State Workmen's Insurance Fund. The department shall make assessments and collect moneys pursuant to this section of the act. Assessments shall be based on the ratio that such insurer's or self-insurer's payments of compensation bear to the total compensation paid in the year preceding the year of assessment. The total amount to be assessed shall be one hundred percent of the amount reimbursed to insurers and self-insurers in the preceding year pursuant to this section, except that the first annual assessment made under this act shall be in the amount of two hundred

fifty thousand dollars ($250,000). The department shall give notice to every insurer and self-insurer under this act, including the State Workmen's Insurance Fund, of the amount assessed against such insurer, self-insurer or the State Workmen's Insurance Fund on or before June 30 of the year following the year upon which the assessment is based: Provided, That notice of the first annual assessment under this act shall be given to every insurer and self-insurer under this act, including the State Workmen's Insurance Fund, within ninety days of the effective date of this amending act. Payment of assessments shall be made to the department within thirty days of receipt of notice of the amount assessed, unless the department specifies on the notices sent to all insurers and self-insurers an installment plan of payment, in which case each such insurer shall pay each installment on or before the date specified therefore by the department within fifteen days after the receipt of such notice, the insurer or self-insurer against which such assessment has been made may file with the department objections setting out in detail the grounds upon which the objector regards such assessment to be excessive, erroneous, unlawful, or invalid. The department, after notice to the objector, shall hold a hearing upon such objections. After such hearing, the department shall record its findings on the objections and shall transmit to the objector, by registered or certified mail, notice of the amount, if any, charged against it in accordance with such findings, which amount or any installment thereof then due, shall be paid by the objector within ten days after receipt of notice of the findings.

No suit or proceeding shall be maintained in any court for the purpose of restraining or in anywise delaying the collection or payment of any assessment made under this subsection but every insurer or self-insurer against which an assessment is made shall pay the same as provided in subsection (b) of this section. Any insurer or self-insurer making any such payment may, at any time within two years from the date of payment, sue the Commonwealth in an action at law to recover the amount paid, or any part thereof, upon the ground that the assessment was excessive, erroneous, unlawful, invalid, in

whole or in part, provided objections, as hereinbefore provided, were filed with the department, and payment of the assessment was made under protest either as to all or part thereof. In any action for recovery of any payments made under this section, the claimant shall be entitled to raise every relevant issue of law, but the findings of fact made by the department, pursuant to this section, shall be prima facie evidence of the facts therein stated. If it is finally determined in any such action that all or any part of the assessment for which payment was made under protest was excessive, erroneous, unlawful, or invalid, the department shall make a refund to the claimant out of the appropriation specified in subsection (c) as directed by the court.

(c) The department shall keep a record of the manner in which it shall have computed the amount assessed against every insurer or self-insurer. Such records shall be open to inspection by all interested parties. The determination of such assessments and the records and data upon which the same are made, shall be considered prima facie correct; and in any proceeding instituted to challenge the reasonableness or correctness of any assessment under this section, the party challenging the same shall have the burden of proof. The fund shall be subject to audit by the Auditor General and a copy of the report of the audit furnished to assessed insurers and self-insurers upon request. The Secretary of Labor and Industry shall be the administrator of the fund and shall have the power to dispense and disburse moneys from the fund for the purpose of payments made pursuant to this section. All moneys in the fund as are required to carry out the purposes of this section are hereby specifically appropriated to the Department of Labor and Industry. The State Treasurer shall be custodian of the fund. Disbursements of moneys pursuant to this section shall be upon final adjudication of requests for payments pursuant thereto.

34 Pa. Code § 127.208. Time for payment of medical bills.

(a) Payments for treatment rendered under the act shall be made within 30 days of receipt of the bill and report submitted by the provider.

(b) For purposes of computing the timeliness of payments, the insurer shall be deemed to have received a bill and report 3 days after mailing by the provider. Payments shall be deemed timely made if mailed on or before the 30th day following receipt of the bill and report.

(c) If an insurer requests additional information or records from a provider, the request may not lengthen the 30-day period in which payment shall be made to the provider.

(d) If an insurer proposes to change a provider's codes, the time required to give the provider the opportunity to discuss the proposed changes may not lengthen the 30-day period in which payment shall be made to the provider.

(e) The 30-day period in which payment shall be made to the provider may be tolled only if review of the reasonableness or necessity of the treatment is requested during the 30-day period under the UR provisions of Subchapter C (relating to medical treatment review). The insurer's right to suspend payment shall continue throughout the UR process. The insurer's right to suspend payment shall further continue beyond the UR process to a proceeding before a workers' compensation judge, unless there is a UR determination made that the treatment is reasonable and necessary.

(f) The nonpayment to providers within 30 days shall only apply to that particular treatment or portion thereof in dispute. If a portion of the treatment is not in dispute, payment shall be made within 30 days.

(g) If a URO determines that medical treatment is reasonable or necessary, the insurer shall pay for the treatment. Filing a petition for review before a workers' compensation judge, does not further suspend the obligation to

pay for the treatment once there has been a determination that the treatment is reasonable or necessary. If it is finally determined that the treatment was not reasonable or necessary, and the insurer paid for the treatment in accordance with this chapter, the insurer may seek reimbursement from the Supersedeas Fund under section 443(a) of the act (77 P.S. § 999(a)).

34 Pa. Code § 127.401. Purpose — review of medical treatment.

(a) Section 306(f.1)(6) of the Act provides a utilization review (UR) process, intended as an impartial review of the reasonableness or necessity of medical treatment rendered to, or proposed for, work-related injuries and illnesses.

(b) UR is a three-step process, that may be requested by multiple parties:

1. The first-step is the initial request that may be made by, or on behalf of, the employer, insurer or employe.

2. The second-step is the request for reconsideration that may be made by, or on behalf of the employer, insurer, employe or health care provider.

3. The third-step is the petition for review of utilization review, that may be filed by, or on behalf of, the employer, insurer, employe or health care provider.

(c) Review of medical treatment shall be conducted only by those organizations authorized as utilization review organizations (UROs) by the Secretary, pursuant to the process set forth in § 127.650 through § 127.670.

34 Pa. Code § 127.403. Assignment of cases to UROs.

The Bureau will randomly assign requests for UR to authorized UROs. An insurer's obligation to pay medical bills

within 30 days of receipt shall be tolled only when a proper request for UR has been filed with the Bureau in accordance with the provisions of this Subchapter.

34 Pa. Code § 127.451. Initial requests for utilization review — who may file.

Initial requests for UR may be filed by an employe, employer or insurer. Health care providers may not file initial requests for UR.

34 Pa. Code § 127.452. Initial requests for utilization review — filing and service.

(a) A party seeking UR of treatment rendered under the Act shall file the original and 8 copies of a form prescribed by the Bureau as an initial request for utilization review. All information required by the form must be provided. Where available, the filing party shall attach authorizations to release medical records of the providers listed on the request.

(b) The initial request for UR shall be served on all parties and their counsel (if known) and the proof of service on the form shall be executed. If the proof of service is not executed, the request for UR will be returned by the Bureau.

(c) Initial requests for UR shall be sent to the Bureau at the address listed on the form.

34 Pa. Code § 127.453. Initial requests for utilization review — assignment by the Bureau.

(a) The Bureau will randomly assign a properly filed request for UR to a certified URO (Utilization Review Organization).

(b) The Bureau will send a notice of assignment of the request for UR to the URO; the employe; the employer or insurer; the health care provider under review, and the attorneys for the parties, if known.

34 Pa. Code § 127.467. Duties of reviewers — generally.

Reviewers shall apply generally accepted treatment protocols as appropriate to the individual case before them.

34 Pa. Code § 127.469. Duties of reviewers — consultation with provider under review.

The URO shall give the provider under review written notice of the opportunity to discuss treatment decisions with the reviewer. The reviewer shall initiate discussion with the provider under review when such a discussion will assist the reviewer in reaching a determination. If the provider under review declines to discuss treatment decisions with the reviewer, a determination shall be made in the absence of such a discussion.

34 Pa. Code § 127.471. Duties of reviewers — finality of decisions.

(a) Reviewers shall make a definite determination as to whether the treatment under review is reasonable or necessary. Reviewers may not render advisory opinions as to whether additional tests are needed. In determining whether the treatment under review is reasonable or necessary, reviewers may consider whether other courses of treatment exist. However, reviewers may not determine that the treatment under review is unreasonable or unnecessary solely on the basis that other courses of treatment exist.

(b) If the reviewer is unable to determine whether the treatment under review is reasonable or necessary, the reviewer shall resolve the issue in favor of the provider under review.

34 Pa. Code § 127.476. Duties of UROs — form and service of determinations.

(a) Each determination rendered by a URO on the merits shall include a form prescribed by the Bureau as a medical

treatment review determination face sheet and the reviewer's report. The face sheet shall be signed by an authorized representative of the URO.

(b) When a determination is rendered against the provider under review on the basis that no records were supplied by the provider, the determination shall consist only of the face sheet. However, in such cases, the face sheet shall clearly indicate that the basis for the decision is the failure of the provider under review to supply records to the URO.

(c) The URO's determination, consisting of both the face sheet and the reviewer's report, shall be served on the employe, the insurer or employer, the provider under review, the attorneys for the parties (if known), and the Bureau.

(d) The URO shall also serve a copy of a form prescribed by the Bureau for filing requests for reconsideration on all parties and their attorneys (if known).

34 Pa. Code § 127.501. Reconsideration of initial utilization review determinations — who may file.

If the provider under review, the employe, the employer or the insurer disagrees with the initial UR determination rendered, a request for reconsideration may be filed with the Bureau.

34 Pa Code § 127.502. Reconsideration — time for filing.

Within 30 days of receipt of the initial UR determination the party requesting reconsideration shall file with the Bureau the original and 8 copies of the form prescribed by the Bureau as a request for reconsideration. Requests for reconsideration shall be sent to the Bureau at the address listed on the form.

34 Pa. Code § 127.503. Reconsideration — service.

(a) The request for reconsideration shall be served on all parties and their attorneys (if known). The proof of service on the request for reconsideration shall be executed.

34 Pa. Code § 127.509. Assignment of reconsideration to reviewer by URO.

(a) The URO shall forward the medical records used for the initial UR, together with any additional records supplied by the provider under review, to a reviewer other than the reviewer who performed the initial UR. The reviewer performing the reconsideration shall be licensed by the Commonwealth of Pennsylvania in the same profession and Board-certified in the specialty or sub-specialty of the provider under review. In the case of physicians, Board-certification shall be by an accredited specialty board.

34 Pa. Code § 127.512. Reconsideration — form and service of determination.

(a) The determination by a URO on a reconsideration shall be in the form prescribed by § 127.476 (relating to form and services of determinations).

(b) The determination by a URO on a reconsideration shall be served in accordance with the requirements prescribed by § 127.476 (relating to form and service of determinations).

34 Pa. Code § 127.551. Petition for Review by Bureau of utilization review determination.

If the provider under review, the employe, the employer or the insurer disagrees with the determination rendered on reconsideration, a request for review by the Bureau may be filed on a form prescribed by the Bureau as a petition for review of a utilization review determination.

34 Pa. Code § 127.556. Petition for Review by Bureau — *de novo* hearings.

The hearing before the Workers' Compensation Judge shall be a *de novo* proceeding. The Workers' Compensation Judge shall not be bound by any prior determinations made during the UR process.

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No. 97-2000 and 97-2030

IN THE
SUPREME COURT OF THE UNITED STATES

October Term, 1997

AMERICAN MANUFACTURERS MUTUAL INSURANCE COMPANY, et al., Petitioners

v.

DELORES SCOTT SULLIVAN, et al., Respondents

ON PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

BRIEF IN OPPOSITION

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*LORALYN MCKINLEY
McKinley and Vonier
1333 Race Street
Philadelphia, PA 19107
(215) 569-1644

Counsel for Delores Scott Sullivan, William Battle, Anthony Cancila, Louis Baumgartner, and Class Plaintiffs

ALAN B. EPSTEIN
Jablon Epstein
The Bellevue, Ninth Fl.
Broad Street at Walnut
Philadelphia, PA 19102
(215) 790-0300
Counsel for Charles Matthews, Christopher Costello, Lisa Lex, Susan Hansen, Terrence Ervine, William C. Dillon, and Class Plaintiffs

**Counsel of Record*

Thomas J. O'Brien
Galfand, Berger, Lurie,
Brigham Jacobs, Swan,
Jurewicz, & Jensen
1818 Market Street, 23rd Floor
Philadelphia, PA 19103
(215) 665-6814
Counsel for PhilaPOSH

Linda M. Martin
Willig, Williams & Davidson
1845 Walnut Street, 24th Floor
Philadelphia, PA 19103
(215) 656-3600
Counsel for Intervenor
Philadelphia Federation of Teachers

COUNTERSTATEMENT OF QUESTIONS PRESENTED

The Pennsylvania Workers' Compensation Act, 77 Pa. Stat. Ann. Sections 1, *et seq.*, creates a public benefit in workers' compensation benefits, including wage replacement and medical benefits. These benefits constitute a recognized property interest under Pennsylvania law. Pursuant to Sections 306(f.1)(5) and (6), 77 P.S. Sec. 531(5) and (6) of the Act, insurance companies providing workers compensation insurance to Pennsylvania employers are delegated the power by the state to stop injured workers' medical benefits without notice or a prior opportunity to be heard.

1. Do Sections 306(f.1)(5) and (6) of the Pennsylvania Workers' Compensation Act, which provide for the cessation of workers' compensation medical benefits without notice to the injured worker or any pre-deprivation opportunity to be heard, violate the injured workers' right to due process of law?

2. Are Petitioner-Insurers state actors when they deprive injured workers of their workers' compensation medical benefits with the sanction of, and through joint conduct with, the Pennsylvania Bureau of Workers' Compensation in accordance with the procedure set forth in Sections 306(f.1)(5) and (6) of the Act?

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COUNTERSTATEMENT

In 1993 the Pennsylvania legislature amended the Workers' Compensation Act by adding a utilization review procedure which permitted insurers or self-insured employers to stop the medical benefits of thousands of injured workers, without notice and with no pre-deprivation opportunity to be heard. This amendment was part of a legislative package ostensibly directed at cost containment known commonly as "Act 44".

This case challenges the constitutionality of the utilization review provisions contained in Act 44, Sections 306 (f.1)(5) and (6) of the Pennsylvania Workers' Compensation Act, ("the Act").[1] The Respondents all are injured workers who have had their medical benefits stopped. They contend that their due process rights were violated by these provisions, and continue to be, because they constitute an established state procedure which disrupts their right to receive public benefits, in which they have an undisputed property interest, without notice and with no prior opportunity to be heard. *Zinermon v. Burch*, 494 U.S. 113 (1990). They further contend that where, as here, the state administers the benefit program and has exclusive control over the resolution of disputes among the parties, the procedures utilized must conform with the requirements of due process. *Logan v. Zimmerman Brush Co.*, 455 U.S. 420 (1982).

Pursuant to the challenged procedures, a stoppage of medical treatment can only be invoked by an insurer or self-insured employer who must initiate a state process via the Pennsylvania Bureau of Workers' Compensation ("the Bureau") in strict accordance with specific state procedural rules. If the Bureau accepts the employer's application to proceed through utilization review, (and it denies them 20% of the time), it forwards the request to a utilization review organization which it approves and selects for a determination as to whether the claimant's treatment is reasonable and necessary. While this legal process is ongoing, the insurer or employer is permitted to

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[1] 77 Pa. Con. Stat. Ann. Sec. 531(5) and (6).

withhold further treatment to the injured worker. The statute does not provide to the injured worker any notice that his benefits will be terminated nor any pre-termination opportunity to be heard. It then precludes any participation by the injured worker in the utilization review process itself. The first opportunity the injured worker has to submit evidence or speak on his own behalf is in a post-utilization review appeal to a Workers' Compensation Judge, which occurs after the process has been completed, and at least several months after the treatment is stopped. This delay has caused eligible injured workers, who have been receiving medical benefits pursuant to the Act, to suffer unnecessary pain, to experience prolonged disability and time absent from work, and in some cases, permanent and irreparable physical injury.

Action In The District Court

The individual plaintiffs ("Respondents" or "injured workers" herein) in the district court action, were ten individuals who have had their medical benefits stopped through a request for utilization review. They initiated, on behalf of themselves and a class of similarly situated workers' compensation claimants, a facial challenge to the constitutionality of Sections 306(f.1)(5) and (6) of the Act by suing the Commonwealth of Pennsylvania ("the Commonwealth"), through several of its officials who were responsible for designing, implementing, and enforcing the Act. The individual plaintiffs also sued ten insurance companies ("Insurers") and the School District of Philadelphia ("School District"), as representatives of a putative class of defendant insurers and self-insured employers, for depriving them of their medical benefits through the utilization review process. The district court dismissed the insurer defendants by Order dated January 6, 1996 on the ground that they were not state actors. The due process challenge was not dependent upon the Insurers' participation, given the obvious status of the Commonwealth defendants as state actors. Accordingly, the district court proceeded to the due process issue, and by Order dated November 7, 1996, held that the statute satisfied due process because it provided for post-deprivation procedures. In so doing, the district court relied upon a

misinterpretation of this Court's ruling in *Mathews v. Eldridge*, 424 U.S. 319 (1976), for the premise that where a pre-termination *evidentiary hearing* is not required by due process, no form of pre-deprivation process is due at all.

The Third Circuit Decision

Addressing only the unique characteristics of the Pennsylvania Workers' Compensation Act, a panel of the Third Circuit Court of Appeals unanimously held that when invoking the supersedeas provisions of Sections 306(f.1)(5) and (6) of the Act, the Insurers and self-insured employers were state actors. App. 19a. The Third Circuit's state action holding was narrowly tailored to the unique characteristics of the Pennsylvania Act as was made unequivocal by the Court's admonition that "[w]e expressly limit our holding here today [ ] to the unique context in which the instant supersedeas provisions arise." App 19a. As the Court recognized, because of the limited focus of its decision, its state action holding is of little precedential value outside of the Commonwealth of Pennsylvania. App. 17a.

The Third Circuit further held, pursuant to fundamental and well established principles of due process, "that the supersedeas provisions under [Sections 306(f.1)(5) and (6)] violate the dictates of due process by not affording disabled employees notice or an opportunity to be heard before their medical benefits are suspended." App. 33a. The Third Circuit's due process holding was consistent with, and supported by, the well-worn precedents of this Court. *LaChance v. Erickson*, ___U.S.___, 118 S.Ct. 753 (1998); *Cleveland Bd. of Educ. v. Loudermill*, 470 U.S. 532 (1985); *Memphis Light, Gas & Water Div. v. Craft*, 436 U.S. 1 (1978); *Mathews v. Eldridge*, 424 U.S. 319 (1976); *Fuentes v. Shevin*, 407 U.S. 67 (1972); *Goldberg v. Kelly*, 397 U.S. 306 (1970); *Boddie v. Connecticut*, 401 U.S. 371 (1971); *Mullane v. Central Hanover Bank & Trust*, 339 U.S. 306 (1950). Moreover, the Third Circuit's reading of the due process clause does not impose an onerous burden on the Commonwealth of Pennsylvania to remedy the problem, nor

does it exceed the procedural requirements imposed by this Court in similar contexts. *See, e.g. Mathews, supra.* Indeed, the Commonwealth of Pennsylvania, which significantly did not seek a stay of the Third Circuit's mandate and has not chosen to file a Petition for a Writ of Certiorari, already has taken action to remedy the procedural defects identified by the Court.

Subsequent Developments

The Insurers and the School District filed motions to stay the mandate on April 2, 1998. By Order dated April 21, 1998, the Third Circuit denied the motions and the mandate issued accordingly. Since then, the Commonwealth has modified its procedures without significant difficulty or expense. Claimants now receive pre-termination notice that utilization review has been filed, a description of the reasons for the request for review, and a pre-termination opportunity to submit written testimony to the utilization reviewer. While negotiations are continuing as to how the system should be further modified in light of the Third Circuit's decision, the significant due process concerns which prompted this litigation have been largely corrected.

Petitioners' Contentions and Mischaracterizations

Insurers contend that the Third Circuit's narrow holding that the "private insurance companies are state actors when they invoke the supersedeas" provisions under the Pennsylvania statute is in conflict with one published and three unpublished opinions by other federal courts of appeals that have addressed the issue in the context of various other state statutes.[2] Ins. at 8. They also contend that the Third Circuit's due process holding was "expansive" and "novel" because it required that the claimants receive notice and an

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2 Respondents are addressing in this Brief both the petition filed by American Manufacturers' Mutual Insurance Co., et al., 97-2000, and the School District of Philadelphia, 97-2030. Henceforth, the insurers' petition will be referred to as "Ins. at __." The School District petition will be designated as "School at __."

opportunity to be heard *before* their medical benefits (in which they have an undisputed property interest) could be suspended or terminated. This requirement, the Insurers argue, imposes a duty to continue paying for treatment that they, without any medical justification or support, and in contradiction of the view of the claimant's treating physician, deem unreasonable and unnecessary. Insurers' view is not only self-interested, but also ignores the policy concerns underlying the Pennsylvania Workers' Compensation Act.

Coloring the Petitioners' contentions is the specter of unwarranted "judicial intervention." In an apparent attempt to fit the facts of the case into the confines of this Court's decision in *Flagg Brothers*,[3] Petitioners incorrectly characterize the relationship between the employer and the insurer as a purely private contractual arrangement, disregarding completely the lack of *any* contractual relationship between themselves and the injured workers, who are the intended beneficiaries of the Act. The Insurers suggest, on the basis of this faulty hypothesis, that the Act does not create a public benefit system, but, rather, simply regulates and balances the interests of private parties.

Based on these gross mischaracterizations, Insurers incorrectly invoke the discredited substantive due process case, *Lochner v. New York*, 198 U.S. 45 (1945), in support of their position that the Third Circuit's decision attempted to substitute the Court's untutored "conception of proper risk allocation in the insurance industry for that of the state legislators and regulators and the private actors involved", and that the decision disrupted the terms of a private contract between the insurers and the employers by imposing a "judicially created payment obligation" that undermines the Insurers' interest in cost containment. Ins. at 9. Insurers' specious contentions and characterizations are nothing more than a poorly disguised attempt to manufacture issues that they think this Court would be

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3 *Flagg Bros. v. Brooks*, 436 U.S. 149 (1978).

disposed to hear. When Insurers' mischaracterizations are laid bare, the substance of the Third Circuit's decision fails to offer any issues that would warrant this Court's attention.

No Conflict Among the Circuits

Insurers also improperly proffer that this matter must be heard to correct the confusion of conflicting legal precedents among the circuits. They cite one published court of appeals decision, three unpublished courts of appeals decisions, and a Pennsylvania Commonwealth Court decision (that was in effect overruled more than a decade ago by a three-judge constitutional court in *Baksalary v. Smith*, 579 F.Supp. 218 (E.D. Pa. 1984), *appeal dismissed*, 469 U.S. 1146), to support their contention that there is a conflict in the circuits regarding whether insurers are state actors when they invoke supersedeas provisions under various workers' compensation statutes throughout the United States. *Stanescu v. Aetna Life and Cas. Ins. Co.*, 101 F.3d 1393 (2d Cir. 1996); *Fleming v. Workers' Compensation Com'n of Virginia*, 78 F.3d 578 (4th Cir. 1996); *Grenz v. EBI Orion Group*, 1992 WL 158158 (9th Cir. July 9, 1992); *Henderson v. Workmens' Compensation Appeal Board*, 69 Pa. Commw. 613 (1982). This attempt to fabricate a conflict among the circuits completely ignores this Court's repeated teaching that the state action inquiry depends upon the factual context in which the controversies arise. *Lugar v. Edmondson Oil Co.*, 457 U.S. at 939.

The Third Circuit's decision invalidated a singular provision of the Pennsylvania Workers' Compensation Act, a law which contains hundreds of sections and thousands of subsidiary provisions. As to how the provisions at issue here are "typical" of those of other states, the Insurers never explain. Contrary to the Insurers' bald assertion, workers' compensation laws vary in many respects from one state to the next. There is no federal common law of workers' compensation and any court faced with a similar state action analysis under workers' compensation provisions in another state will have to

start not with the *Sullivan* decision, but with the statute at hand.[4] By definition, therefore, there can be no conflict among the circuits in a case such as this, because each circuit court which considers the role insurers and self-insured employers play in a particular workers' compensation system are construing uniquely different state laws. There is no need for this Court to embroil itself in the intricacies of a parochial dispute. Even within the Third Circuit, the decision will have applicability only in Pennsylvania, because the statutes in New Jersey, Delaware, and the Virgin Islands will have to be construed according to their own terms. Accordingly, regardless of decisions in other circuits which may have reached a different conclusion when construing the provisions of another state's workers' compensation statute, by definition the Third Circuit's decision cannot be in conflict with another court's decision regarding another state's statute because the inquiry is fact driven and turns on the subtleties inherent in each state's particular statutory scheme. This Court cannot, and should not attempt to, pronounce a national rule regarding when insurance companies are state actors under the various workers' compensation statutes. This issue can only be resolved on a case by case basis.

Public Benefit vs. Private Contract

This is not a case involving "judicial intervention" or the regulation and balancing of the interests of private parties, as the Insurers would have the Court believe. This case does not involve parties to a private contractual dispute. The workers'compensation system in Pennsylvania is not a private industry, but a public benefit system established by legislative enactment. This may or may not be true in other states.

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[4] For the same reasons that this Court's guidance is unnecessary in the field of workers' compensation law, there will never be a Restatement of Workers' Compensation.

That workers' compensation benefits are public benefits as a matter of law in Pennsylvania is evident from the following: 1) The Pennsylvania Constitution was specifically amended in 1915 in response to strong public pressure to enable the legislature to provide for workers' compensation coverage. Pa. Const. Art 3 § 18; 2) The right to workers' compensation is guaranteed to all workers in Pennsylvania who are not self-employed, and the Commonwealth itself vigorously enforces that right. Workers cannot bargain away their right to workers' compensation coverage, and they may not opt out in favor of their own privately obtained coverage. An injured worker aggrieved by the conduct of his insurance company cannot drop his coverage and shop for a new carrier. The injured worker is not a party to any contract other than the one with his employer; moreover, the employer's duty to provide for workers' compensation does not emanate from a contract or insurance policy, but from state law; 3) Workers' compensation constitutes a *quid pro quo* for the right of workers to sue their employers for damages as a result of workplace injuries. It is the exclusive remedy for such injuries. *Winterberg v. Transportation Insurance Co.*, 72 F.3d 318 (3rd Cir. 1995); 4) The private resolution of workplace injuries through civil litigation was replaced by a publicly administered Bureau which dictates the level of benefits to be paid, the circumstances under which benefits can be paid, as well as those under which they can be suspended and terminated; 5) Workers' compensation has been deemed by the Pennsylvania Courts to be a public benefit, equivalent to "a soldier's right to a pension". *Keller v. Old Lycoming Township*, 286 Pa. Super. 339, 348 n.6, 428 A.2d 1358, 1363 n.6 (1981). *See also Winterberg, supra* (distinguishing workers' compensation from private insurance). The Pennsylvania Supreme Court has recently rejected the premise that workers' compensation benefits are a matter of contract: "The workers' compensation system as it is now structured is purely an exercise of the 'police power' of the Commonwealth regulating the employer-employee relationship. As a result, there is no longer any basis for construing the provisions of

the workers' compensation Act in contractual terms". *Bible v. Commonwealth of Pennsylvania*, 548 Pa. 247 (1997).[5]

The Insurers attempt to minimize the type of deprivation at issue here and to bolster their business as usual contract formulation by denying that medical benefits are at issue at all, characterizing the dispute as one over "bills," rather than treatment, and by insisting that the injured workers can be fully reimbursed later for any loss they incur now. These suggestions contradict the factual context of the Pennsylvania workers' compensation system. More correctly, an injured worker's receipt of medical benefits under the Pennsylvania Act has always been through the receipt of treatment, and not by way of direct payments to claimants. In practice, those benefits are furnished through the payment of medical bills submitted by medical providers to the insurance company or employer. Thus, while it may be true in some sense that "bills" are at issue, those bills are merely the vehicle through which medical benefits are provided under the Act. When the bills are not paid, an injured worker's treatment is ordinarily stopped by the doctor or other medical provider, and benefits are thereby eliminated.

Lochner Is Inapplicable

The Insurers have also resurrected the ghost of *Lochner* in an effort to obscure the true nature of their challenge here, which calls into question the power of a federal court to hold a state law unconstitutional when that law tramples upon vested property rights and denies the procedural rights guaranteed by the Fourteenth Amendment. *Lochner* can rest in peace, however, because the Third

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[5] It should also be noted that in the context of workers' compensation, insurers are treated differently than they are in other insurance contexts. For instance, insurance carriers cannot be sued for bad faith handling of workers' compensation claims. *See Winterberg, supra.* Accordingly, in this context the insurers assume the mantle of immunity generally reserved for the state itself.

Circuit in this case carefully adhered to its prescribed role in our constitutional system. It evaluated the procedures utilized by the Pennsylvania legislature to effectuate its legislative goals, but made no policy judgments whatsoever as to the wisdom or desirability of the legislation itself. Unlike the Insurers, the Court was mindful of the important distinction between a substantive and a procedural due process claim. As a guardian of due process rights, the court undertook the very task which the federal courts are empowered to perform, and must perform, in order to guarantee that Constitutional rights do not fall victim to parochial efficiency and self-interest.[6] *Marbury v. Madison,* 5 U.S. (1 Cranch) 137 (1803); *Martin v. Hunters' Lessee,* 14 U.S. (1 Wheat.) 304 (1816).

REASONS FOR DENYING THE WRIT

I. THE COURT OF APPEALS CORRECTLY FOUND THE INSURERS TO BE STATE ACTORS IN THE CONTEXT OF UTILIZATION REVIEW.

A. The Analysis Below Was Based On Well Established Supreme Court Precedent.

The Court of Appeals held that the private insurers within the Pennsylvania Workers' Compensation system are state actors when they invoke utilization review to terminate claimants' medical benefits without prior notice or an opportunity to be heard. Relying on established precedent, the court examined the relationship among the Commonwealth, employer, and the insurance companies, and found an intimate interconnection between them in the context of the

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[6] Justice Oliver Wendell Holmes once wrote, in this regard: "I do not think the United States would come to an end if we lost our power to declare an Act of Congress void. I do think the Union would be imperiled if we could not make that declaration as to the laws of the several states". O.W. Holmes, Collected Legal Papers at 295-6.

Workers' Compensation system as a whole, and in utilization review in particular. The court further found that the decision by the insurers to terminate injured workers' state-guaranteed entitlements was not self-executing, but, rather, required the direct participation and approval of the state. Thus, far from being an unwarranted extension of the state action doctrine, or, as Insurers contend, a decision devoid of any "coherent theory" of state action, the Third Circuit's decision was logically compelled by the controlling precedents set by this Court. *West v. Atkins,* 487 U.S. 42 (1988); *Tulsa Prof'l.Collection Svcs., Inc v. Pope,* 485 U.S. 478 (1988); *Lugar, supra.* Those have established a two-part inquiry for discerning state action on the part of purportedly private parties:

> First, the deprivation must be caused by the exercise of some right or privilege created by the state or by a rule of conduct imposed by the state or by a person for whom the state is responsible...Second, the party charged with the deprivation must be a person who may fairly be said to be a state actor.

Lugar v. Edmondson Oil, 457 U.S. 922, 937 (1982).

In an attempt to manufacture an error of law warranting review, Insurers complain that the opinion of the Court of Appeals did not fit its state action analysis into predetermined state action templates they assert have been required by this Court. Contrary to this assertion, this Court has never adopted a formulaic and rigid approach to state action. Although it has found state action where a symbiotic relationship exists between the private entity and the state, *Burton v. Wilmington Parking Authority,* 365 U.S. 715, 722 (1961); where the private entity is engaged in a public function, *Marsh v. Alabama, 326 U.S. 501 (1946);* and where there is a close nexus between the state and the private entity, *Flagg Bros.,* 436 U.S. at 157-59; *Blum v. Yaretsky,* 457 U.S. 991 (1982), this Court has never decreed that state action is necessarily absent in other contexts. To the contrary, this Court has repeatedly indicated that determining

whether an otherwise private actor is a state actor in a given circumstance is necessarily a "fact-bound inquiry." In *Lugar*, for instance, the Court did not utilize any of the three tests espoused by the Insurers, and eschewed reliance upon any one test, because it was unclear "whether these different tests are actually different in operation or simply different ways of characterizing the necessarily fact-bound inquiry which confronts the court in such a situation." *Lugar*, 457 U.S. at 941. "For only by sifting through facts and weighing circumstances can the nonobvious involvement of the State in private conduct be attributed its true significance." *Id.* at 939.

The Court's most recent state action cases, none of which were cited by Insurers in framing their assault on the lower court's state action holding, have not relied upon any distinct test for a determination of state action but have looked to the totality of the circumstances involved in the situation before it. *See e.g. West, supra; Tulsa, supra; Edmondson v. Leesville Concrete Co.*, 500 U.S. 614 (1991). In *Edmondson*, the Court stated that in determining whether a private litigant is to be deemed a state actor, it is appropriate to examine 1) the extent to which the actor relies on governmental assistance and benefits; 2) whether the actor is performing a traditional government function; and 3) whether the injury caused is aggravated in a unique way by the incidents of governmental authority. Thus, contrary to the analysis espoused by the Insurers, this Court did not state a series of discrete tests and apply them separately to determine whether each by itself was satisfied. Rather, as it had in *West* and *Tulsa*, the Court considered a number of factors and weighed them to determine whether, all things considered, the otherwise private conduct could fairly be deemed state action. It was this analysis which governed the Third Circuit's decision.

B. Applying Established State Action Analysis, The Court Below Properly Found State Action

There is simply no foundation for the Insurers' suggestion that the lower court's analysis constitutes a misapplication of this Court's precedents or fails to conform to a specific theory of state action.[7] Moreover, it is clear from the thorough analysis conducted by the court below that its conclusion regarding the Insurers as state actors is well supported and correct. The Third Circuit conducted a fact intensive inquiry which focused on the relationship between the state and the insurance carriers in providing injured Pennsylvania employees their "constitutionally protected entitlement" to medical treatment under the Act. App. 13a-14a. First, the court recognized that workers' compensation benefits in Pennsylvania, unlike other types of insurance, are a public benefit, guaranteed by statute and protected by the state constitution. App. 14a. Second, the court focused on the fact that "[t]he system is mandatory; an employee cannot opt-out of the Pennsylvania Workers' Compensation scheme." App. 14a. Third, the court observed that the system is entirely state-created, self-contained, and administered by the government alone. App. at 14a. Fourth, in defining the insurers' role in the context of the statute, the court recognized that, pursuant to the elaborate statutory scheme enacted by the state, the burden of ensuring that injured employees receive their guaranteed benefits is placed on the employer, who has the option of fulfilling its statutory duty by either

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[7] Certainly, if Act 44 had granted to workers denied a medical benefit the power automatically to invoke an order commanding payment of that benefit by the private insurer of his or her employer, the Insurers would have promptly (and correctly) presented to the courts the argument that the injured worker had improperly been cloaked with the mantle of state action. No lesser status should be accorded to private insurers where the insurers were granted that power to stop medical benefits. *Cf. Dowty Corp. v. Workers' Compensation Appeal Board (McKelvey)*, 152 Pa. Commw. 467 (1993) (Employers/insurers unsuccessfully challenged obligation to pay for treatment that they deemed unnecessary on Due Process and Equal Protection grounds).

self-insuring, or obtaining workers compensation insurance from a private carrier or the State Workers' Insurance Fund, a Commonwealth agency. When the employer obtains workers' compensation insurance, the insurer assumes all of the employer's obligations and liabilities under the Act, and in effect, stands in the employer's shoes vis-a-vis both the state and the employee. Accordingly, as the court reasoned, "[a]lthough the insurance companies are private entities, when they act under the construct of the Workers' Compensation system, they are providing public benefits which honor State entitlements. In effect, they become an arm of the State, fulfilling a uniquely governmental obligation under an entirely state-created, self-contained public benefit system." App. 14a-15a. Finally, the Court found significant the fact that "[t]he right to invoke the supersedeas, or to stop payments, is a power that traditionally was held in the hands of the State." App. 15a. Under the Pennsylvania scheme, the State delegated this traditional state power to the insurance carriers, thereby empowering them to "compromise an employee's State-created entitlement."[8] App. 15a. Moreover, the power of the insurers and self-insured employers to terminate an employee's benefits is not self-executing: "The insurers have no power to deprive or terminate such benefits without permission and participation of the Commonwealth . . . [which] is intimately involved in any decision by an insurer to terminate an employee's constitutionally protected benefits because an insurer cannot maintain a supersedeas of medical payments without first obtaining authorization from the Bureau." App. 15a. As the court below reasoned:

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[8] The Commonwealth cannot avoid its constitutional and statutory duty to provide benefits by delegating that responsibility to a private party or entity. *West v. Atkins*, 487 U.S. 42, 56 (1988). In *West*, the Court reasoned that "[c]ontracting out prison medical care does not relieve the State of its constitutional duty to provide adequate medical treatment to those in its custody, and it does not deprive the State's prisoners of the means to vindicate their Eighth Amendment rights." *Id.*

> However this authorization may be characterized, any deprivation that occurs is predicated upon the State's involvement... The [Bureau] is intimately involved throughout, and without that involvement the supersedeas could not operate... [The Act] inextricably entangles the insurance companies in a partnership with the Commonwealth such that they become an integral part of the state in administering the statutory scheme. This relationship more than suffices to satisfy the constitutional requisites under the tests--varied though they may be--for state action.

App. at 19a.

In short, like the nonclaim statute at issue in *Tulsa*, "the supersedeas could not operate" without the direct involvement of the Commonwealth. App. 15a. There is simply no reason for this Court to grant review in a case in which the lower court so closely scrutinized the factual context of the statutory scheme, particularly in light of the obvious and pervasive state entanglement between the Commonwealth, the employers, and the insurance companies within that state-created and state-run system.

C. The Decision Below Does Not Conflict With Other Circuits.

Insurers' alternative argument that *certiorari* should be granted because the state action question splits the Circuits is equally baseless. The Third Circuit's state action analysis in this case was highly dependent upon the operation of the unique characteristics of the Pennsylvania workers' compensation system and the particular characteristics of the utilization review procedures being challenged. The workers' compensation systems of *each* of the fifty States are necessarily different from one another. Each is the product of goals, breadth of coverage, and means of enforcement which differ from

state to state. These differences among the states preclude the factual uniformity needed to create a split in the circuits. Any decision involving the workers' compensation system of any one state *must* be, as the Court of Appeals pointed out below, "necessarily inapposite" to the cases from another State. App. 17a.. Such a case, by definition, fails to call out for national guidance by this Court.

To bolster their conflict argument, Insurers point to four Courts of Appeals that have reached differing conclusions as to whether private insurers acting pursuant to various state workers' compensation statutes are state actors. Three of the four Courts of Appeals decisions cited by Insurers, however, are so factually directed that they were ordered by the issuing court to be unpublished, and *cannot* be cited under the rules of the courts which issued them: *Stanescu v. Aetna Life and Cas. Ins. Co., supra;*[9] *Fleming v. Worker's Compensation Com'n of Virginia, supra;*[10] *Grenz v. EBI Orion Group, supra.* [11] Because the cases cannot bind even courts in their own circuits, it is highly improper to argue that they establish a conflict in the circuits that warrants this Court's review.

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[9] In large capital letters at the top of the electronically obtained unpublished opinion the following admonishment pursuant to Second Circuit rule appears: "NOTICE: THIS SUMMARY ORDER MAY NOT BE CITED AS PRECEDENTIAL AUTHORITY".

[10] The electronically retrieved version of the unpublished decision has a notice warning that the "citation of unpublished dispositions is disfavored." *Fleming* uses only two paragraphs to deal with the issue of state action, and, of course, necessarily deals with the workers' compensation system as statutorily created by the Commonwealth of Virginia. The decision affirms the grant of a Motion to Dismiss and does not set forth the facts of the Virginia system.

[11] The electronically retrieved version of the unpublished opinion states that "dispositions other than opinions or orders designated for publication are not precedential and should not be cited."

Moreover, each decision cited arises in the context of a different statutory framework than the one at issue here. *Stanescu*, for instance, distinguished itself from *Baksalary v. Smith*, 579 F. Supp. 218 (E.D.Pa. 1984), a case which involved a strikingly similar provision of the Pennsylvania's Workers' Compensation Act, and stated that the outcome might have been different if the workers' compensation system in Connecticut (locus of the case) contained certain features of the Pennsylvania system.[12] *Accord Grenz v. EBI/Orion Group* (distinguishing Montana statute from Pennsylvania). The only published decision the Insurers could properly cite is *Barnes v. Lehman*, 861 F.2d 1383 (5th Cir. 1988), but even that decision does nothing to advance their argument. *Barnes* involved the statutory workers' compensation system in Texas in 1988. As the *Sullivan* opinion itself pointed out, there are several distinguishing differences between the Texas system and the Pennsylvania system, making the case "necessarily inapposite" to *Sullivan.*[13] App. 17a.

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[12] It is worth noting that one of the judges in the *Stanescu* decision is the Honorable Louis H. Pollak, of the Eastern District of Pennsylvania who was sitting by designation, who authored the opinion in the *Baksalary* decision for the three Judge panel, and who would therefore clearly understand the differences whereof he speaks. *Stanescu* cannot be seriously compared to *Sullivan* in any event, because the injured workers in that case relied solely upon the exclusivity of workers' compensation for work injuries in Connecticut as their predicate for state action. The Court quite correctly pointed out that regulation, standing alone, is insufficient to render private conduct state action. In *Sullivan*, the state action analysis was far more developed, and relied upon exclusivity as just one of the many factors in the state action equation. *Stanescu* is also distinguishable from the present case because there was no interdependence between the insurers and the state and there was no state review of any kind.

[13] The *Sullivan* Court noted several distinguishing features: the State's recommendation that Mr. Barnes' compensation be reinstated did not need to be followed by the insurer (and was not); it was unclear whether employers and employees could opt out of the system; it was not clear whether State involvement

The Court's state action holding is fact-based, and relies on the intricacies and subtleties created by the Pennsylvania statutory scheme. There is no reason for this Court to expend its time and its guidance on an issue that can never arise in the same way elsewhere.[14]

II THE THIRD CIRCUIT'S DUE PROCESS HOLDING DOES NOT WARRANT REVIEW

A. The Due Process Issue Is Moot.

The Third Circuit held that Sections 306(f.1) (5) and (6) of the Pennsylvania statute violated the due process clause of the Fourteenth Amendment by denying claimants adequate notice or an opportunity to be heard prior to the termination of their medical benefits. At a minimum, the court held, due process requires "(1) timely and reasonable notice of the imminent suspension of the medical benefits and treatment *before* suspension takes place; (2) a description of the reasons why utilization review has been invoked; (3) an opportunity and time to submit a personal statement in writing regarding the employee's view of the reasonableness and/or necessity of the disputed medical treatments; and (4) a description of the procedures under which the employee can appeal an adverse determination." App. 33a.

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was required before termination of benefits. App. *at* 17a.

[14] The one decision cited by Insurers as showing opposition to *Sullivan* by "the state courts [*sic*] of Pennsylvania" [Insurers' Petition at p. 14], *Henderson v. W.C.A.B. (Rockwell Intern., Inc.)*, 69 Pa.Cmwlth. 613 (1982), is a Commonwealth Court case that dealt with the very statute found unconstitutional shortly thereafter by the *Baksalary* decision. One of the main bases of the *Henderson* decision was that "the suspension of disability benefits essentially involved a private contractual matter between the parties[.]" *Id.* The Pennsylvania Supreme Court has recently ruled that, because of changes to the Workers' Compensation Act, "there is no longer any basis for construing its provisions in contractual terms." *Bible v. Com., supra*. Similar arguments by Insurers must also fail.

Subsequent to the Third Circuit's decision, the Commonwealth of Pennsylvania, which has not filed a Petition for a Writ of Certiorari, modified its procedures. A new form has been issued, and injured workers now receive pre-termination notice that utilization review has been filed, a description of the reasons for the request for review, and an opportunity to submit written testimony to the utilization reviewer prior to the termination of the medical benefits. The changes made by the Commonwealth of Pennsylvania to the utilization review procedures render the due process issues moot, and, accordingly, both Petitions for Writ of Certiorari should be denied.[15] *Hall v. Beals*, 396 U.S. 45, 48 (1969)("we review the judgment below in the light of the [ ]statute as it now stands, not as it once did").

B. Whether Medical Benefits Are Property Was Not Pressed Or Passed Upon Below

This Court has repeatedly stated that it will not grant a Petition for a Writ of Certiorari unless the issue has been "pressed or passed upon" in the Court of Appeals. *Illinois v. Gates*, 462 U.S. 213, 222-223 (1983). An issue is not considered "pressed or passed upon" unless there has been a real contest on the issue in the court below. *Illinois*, 462 U.S. at 222-223. Accordingly, the mere restatement or application of settled law is insufficient to satisfy the requirement. *Id.*

Notwithstanding this basic principle of appellate review, Petitioner-School District argues that the medical treatment that the injured workers were receiving prior to termination is not property within the meaning of the Fourteenth Amendment because the injured worker does not have a constitutionally protected interest "in any

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[15] Because the due process issues are now moot, the question of state action on the part of the insurers has become purely academic, and therefore does not warrant review by this Court.

medical care a worker chooses merely because the worker believes the treatment provides relief." School at 8. No such contention was ever raised or contested by any party, either in the District Court or in the Court of Appeals. Indeed, Senior Judge Garth noted that "[n]either party disputes the district court's ruling that workers' compensation benefits are a constitutionally protected property interest subject to scrutiny under the Due Process Clause of the Fourteenth Amendment."[16] App. 20 n.23. Because the issue was never "pressed or passed upon" in the Court of Appeals, or the District Court, the School District's Petition for a Writ of Certiorari should be denied. *Illinois*, 462 U.S. 222-223.

C. Workers' Compensation Medical Benefits Are "Property" Under Pennsylvania Law

The School District's argument that the benefits at issue here are not constitutionally protected property grossly mischaracterizes the nature of the interest involved and contradicts well established state and federal law. This Court has consistently held that the property rights protected by the due process clause of the Fourteenth Amendment do not flow from the Constitution, but rather, "they are created and their dimensions are defined by existing rules or understandings that stem from an independent source such as state law - - rules or understandings that secure certain benefits and that support claims of entitlement to those benefits." *Board of Regents v. Roth*, 408 U.S. 564, 577 (1972). Pursuant to the Pennsylvania Constitution, the Pennsylvania Workers' Compensation Act, and the decisions of the Pennsylvania Courts interpreting them, the medical

[16] None of the parties raised or contested the issue in the District Court. Although there was no contest, the District Court began its opinion by citing to well established precedent and holding that medical benefits constituted property protected by the Fourteenth Amendment. App. 68a.

benefits that the Respondents were receiving are clearly property as defined by Pennsylvania law.

The Pennsylvania Constitution was amended in 1915 to enable the state legislature to provide for workers' compensation coverage. Pa. Const. Art. 3 Sec. 18. The Pennsylvania Legislature has created a system that guarantees to all workers injured on the job the right to workers' compensation benefits, including medical treatment.[17] Pursuant to the terms of the Act, this right is guaranteed and cannot be bargained away, and neither the employer nor the employee can opt out of the system. A Pennsylvania worker injured on the job therefore has a statutorily guaranteed "claim[ ] of entitlement to those benefits." *Roth*, 408 U.S. at 577. The Act provides that these benefits are not terminable at will, and thus they are clearly property within the meaning of the Fourteenth Amendment. *Memphis Light, Gas, and Water Division v. Craft*, 436 U.S. 1, 12, (1978).

The Pennsylvania courts that have construed the provisions of the Workers' Compensation Act support this conclusion. Consistently, the state courts have recognized that the statutorily guaranteed entitlement to workers' compensation benefits is a form of property. *Congleton v. Department of Public Welfare*, 48 Pa. Commw. 615, 617 n.2 (1980) ("we find no merit in appellant's argument that a pending workmen's compensation claim is not property"); *Sayre v. Textile Machine Works*, 129 Pa. Super. 520, 523 (1938) (". . . compensation payments . . . are intended as a substitute for wages which the employee would have earned if he had not been injured"); *See also Kelmon v. Reiber*, 161 Pa. Super. 169 (1947) and *Keller v. Old Lycoming Township*, 286 Pa. Super. 339, 348 n. 6 (1981). Likewise, the federal courts that have addressed this issue have held that Pennsylvania Workers' Compensation benefits are

[17] The only exception is self-employed workers.

property protected by the Fourteenth Amendment. *Baksalary v. Smith*, 579 F.Supp. 218, 224-25 (E.D. Pa. 1984).

Petitioner-School District attempts to escape this well established line of state and federal precedent by characterizing the injured workers' interest as nothing more than an expectation in a particular kind of treatment that the "worker chooses merely because the worker believes the treatment provides relief." School at 8. This contention is simply wrong. As a factual matter, all of the injured workers were receiving paid medical treatment at the time their benefits were terminated. Therefore, the injured workers had more than a mere expectation in treatment; they had a fully vested right to treatment. Moreover, this treatment was prescribed by a health care professional, and not arbitrarily chosen by the injured worker, as suggested by the School District. In all of these cases, the injured worker had already been deemed eligible for the treatment under the provisions of the statute, and therefore had "a legitimate claim of entitlement to it." *Roth*, 408 U.S. at 577.

D. The Third Circuit Properly Invalidated The Statute Because It Provided For No Pre-deprivation Notice Or Opportunity To Be Heard

The Third Circuit held that the utilization review provisions violate due process in two respects. First, the statute provides no notice at all to injured workers prior to the termination of their medical benefits, a contention which the state conceded at oral argument, and which the Insurers, themselves, concede in their Petition. App. at 23a; Ins. at 22 n.12. Second, the statute offers the injured workers no opportunity at all to challenge the termination of their medical benefits until many months (at least) after the deprivation of those benefits has been effected. App. at 30a.

The Third Circuit found the lack of pre-termination notice to the injured worker to be constitutionally fatal because it

> does not explain that a supersedeas or suspension of one's medical benefits may result nor does it explain what utilization review entails. In addition, it does not inform an employee of any procedures under which the employee can protest the suspension of the medical benefits or contest the merits on which the proposed deprivation is based.

App. 23a. Moreover, the court observed, the notice arrives after the benefits have already been terminated. App. 24a. The Court concluded that inadequate notice effectively strips an employee of his/her ability or opportunity to protest or minimize an unjustified deprivation. App. 24a. Furthermore, the court held that under the circumstances presented, due process requires some sort of opportunity to be heard regarding the basis of the proposed termination *before* it takes place. App. 25.

The Third Circuit's holding is a mainstream decision consistent with a well-settled and unbroken line of precedent from this Court, which sets forth two basic tenets of due process. First, "notice reasonably calculated under all the circumstances to apprise interested parties of the pendency of the action" is constitutionally required prior to the deprivation of a protected property interest. *Memphis Light, Gas & Water Co. v. Craft, supra*; *Fuentes v. Shevin, supra*. Second, due process ordinarily requires an opportunity for "some kind of hearing" prior to the deprivation of such an interest. *Memphis Light, Gas & Water, supra*, 436 U.S. at 19, *citing, Boddie v. Connecticut*, 401 U.S. 371, 379 (1971). *See also Logan v. Zimmerman Brush Co.*, 455 U.S. 420, 437 (1982). In a case such as this, in which an established state procedure is being challenged, this Court has always required notice and an opportunity to be heard *before* the deprivation unless exigent circumstances exist or pre-deprivation process would be demonstrably impracticable. *Zinermon v. Burch*, 494 U.S. 113 (1990); *Parratt v. Taylor*, 442 U.S. 584 (1981). This is true even if extensive post-deprivation remedies are afforded. *Connecticut v. Doehr*, 501 U.S. 1 (1991).

This Court has applied these principles in numerous factual contexts to invalidate state laws that failed to provide any notice or opportunity to be heard before the deprivation of a protected liberty or property interest. *Connecticut v. Doehr*, 501 U.S. 1 (1991)(real estate attachment); *Cleveland Board of Education v. Loudermill*, 470 U.S. 532 (1985)(public employment); *Logan v. Zimmerman Brush*, 455 U.S. 422 (1982)(cause of action); *Memphis Light, Gas & Water Division v. Craft*, 436 U.S. 862 (1978)(utilities); *Goss v. Lopez*, 419 U.S. 565 (1975)(public education); *Fuentes v. Shevin*, 407 U.S. 67 (1972)(personal property); *Bell v. Burson*, 402 U.S. 535 (1971)(drivers' licenses); *Goldberg v. Kelly*, 397 U.S. 254 (1970)(welfare benefits). These cases and the due process principles enunciated in them apply to interim deprivations of property as well as to final deprivations. *See e.g. Connecticut v. Doehr*, 501 U.S. at 12; *Arizona v. California*, 460 U.S. 605, 638 n. 28 (1983); *Webb's Fabulous Pharmacies, Inc. v. Beckwith*, 449 U.S. 155, 164 (1980).

Because no one disputes that the challenged statute permits a recognized property right to be disrupted without any pre-deprivation notice, the Third Circuit's decision that the statute is unconstitutional would have to stand regardless of how this Court might dispose of the other due process contentions raised by the Insurers. Because inadequate notice, standing alone, is enough to render the statute unconstitutional, *see e.g., Tulsa, supra; Memphis Light, supra; Mullane v. Central Hanover Trust Co.*, 339 U.S. 306, 314 (1950), there is no reason for the Court to examine the remaining constitutional issues because they will have no impact upon the ultimate resolution of the case.

The Insurers have alleged no exigency that would justify a departure from the fundamental requirements of pre-deprivation process. Neither is impracticability a barrier, as evidenced by the fact that, prior to the 1993 amendments, the Commonwealth required notice and an opportunity to be heard before medical benefits could be terminated. 77 P.S. Sec. 531. Moreover, since the *Sullivan* decision, the Commonwealth has modified the utilization review process to

require notice and an opportunity to be heard. Even in those rare situations in which this Court has approved post-deprivation procedures alone, it has required some assurance against arbitrary and unfounded interference in the enjoyment of the property interest, *e.g. Connecticut v. Doehr, supra. See also Gilbert v. Homar*, ___ U.S. ___, 117 S.Ct. 1807, 1812 (1997)("An important government interest, accompanied by a substantial assurance that the deprivation is not baseless or unwarranted, may in limited cases demanding prompt action justify postponing the opportunity to be heard until after the initial deprivation"), *quoting F.D.I.C. v. Mallen*, 486 U.S. 230, 240 (1988). Here, there is no such assurance. The request for utilization review is not required to be based on any medical criteria whatsoever, or supported by even the slightest indicia of reasonableness. This Court has found on numerous occasions that "one-sided, self-serving, and conclusory submissions" elevate the risk of erroneous deprivation to an unacceptable level. *Connecticut v. Doehr, supra; Fuentes v. Shevin, supra*, 407 U.S. at 83. Thus, the Third Circuit's determination that the lack of a prior opportunity to be heard renders the statute unconstitutional must be upheld.

Once it is established that pre-deprivation process is due, the Court's decision in *Mathews* defines the extensiveness of the procedures to be afforded. The Third Circuit straightforwardly applied the three *Mathews* factors and concluded that the injured workers must receive an opportunity to submit a personal statement in writing to the utilization reviewer before their benefits can be constitutionally severed. That court looked first at the private interests involved, including the injured workers' interest in the relief that medical treatment provides, and the interest of the insurers and employers in not paying for unnecessary and unreasonable medical treatment. While the employers' interest was pecuniary, the injured workers' was not. The circuit found the workers' interest in medical treatment to be significant, and not protected by an after-the-fact

remedy. App. 28a.[18] (*See e.g. Memorial Hospital v. Maricopa County*, 415 U.S. 250, 259-60 (1974)("To allow a serious illness to go untreated until it requires emergency hospitalization is to subject the sufferer to the danger of a substantial and irrevocable deterioration in his health"). The circuit further held that the risk of erroneous deprivation was unacceptably high, given the injured workers' lack of notice and opportunity to be heard during the utilization review process. Although the medical review focuses upon the records of the treating physician, and the physician must be given the chance to speak with the reviewer, the Court was "hard-pressed to believe that the portrait of the employee's illness and treatment ... [could be] ....complete without a statement or other input from the injured worker". App. 29a.

According to the Court of Appeals, the governmental interest (which the Insurers fail to consider) would adequately be served by permitting the injured worker a pre-termination opportunity to respond. The government has a legitimate interest in containing costs and ensuring that benefits are paid only for reasonable and necessary treatment, but it has an equally compelling interest in preventing the erroneous termination of benefits to injured workers who have a continuing need for them. On balance, therefore, some sort of pre-termination process is necessary. App.30a. At a minimum, the Third Circuit concluded, "the employee should be granted the opportunity to present additional evidence *such as* his/her personal testimony in writing as to the reasonableness and necessity of the disputed treatment". App. 31a (emphasis added).

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[18] It should be noted that the Pennsylvania courts have balanced the two interests and come to the same conclusion. *Stonebraker v. Workers' Compensation Board of Review*, 163 Pa. Commw. 468, 475 (1994)(despite employer's economic interest in terminating medical treatment which is not necessary as soon as possible, injured workers should be protected from potentially devastating economic or medical consequences stemming from unwarranted terminations of medical benefits).

The result obtained below was well within the parameters set forth in *Mathews*. Indeed, *Mathews* required more. In this context, the insurers' contention that the Third Circuit misapprehended the *Mathews* requirements based upon this Court's decision in *Doehr* borders on the frivolous. According to the Insurers, *Doehr* changed the *Mathews* analysis by requiring the court to balance two private interests, rather than a private interest vis-a-vis a governmental interest, where competing private interests are concerned. To the contrary, *Mathews* has always required an analysis of the private interests concerned in any procedural scheme.

The court below was well aware that two private interests needed to be weighed in this case. The Court dutifully weighed both interests and concluded that the injured workers' interest in their medical benefits outweighed the insurers' pecuniary interest in non-payment, an interest which can be reimbursed in the event that payment is ultimately deemed to be unreasonable and unnecessary.[19] Insurers' allegation that the Court refused to consider their interest is totally disingenuous. Whether *Doehr* added a second private interest

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[19] The Insurers' contention that they cannot be reimbursed for payments later determined not to be owed is misleading at best. In fact, the insurers admit that they can apply to a supersedeas fund which provides for reimbursement. *Cf.* Ins. at 4 (alleging that insurers cannot recoup payments made for unnecessary and unreasonable treatment) and at p.2 n.1 (conceding access to supersedeas fund to reimburse for such payments). Although this fund is funded by the insurance carriers, this is a system which spreads the risk throughout the industry for unwarranted payments. It is not correct to suggest that no reimbursement to the insurer is available. It is the injured workers' interest in timely treatment which cannot be rectified in any manner by a post-deprivation remedy.

to the equation or not, the Third Circuit considered *all* the relevant interests and weighed them appropriately.[20]

Underlying the Insurers' argument is the fundamental complaint that due process was found to attach at all, because what is at issue here, in their view, is not the deprivation of medical benefits, but the timing of payment for treatment already received. Bills, not benefits, is how the Insurers would like to characterize what is at stake here. Insurers' argument grossly mischaracterizes the record in the court below, and the clear import of a request for utilization review. Medical bills are the vehicle through which medical benefits are delivered to injured workers in Pennsylvania. Unless the doctor or other medical provider agrees to work gratuitously,[21] once payments stop, so does the treatment. Several of the injured workers in this action have alleged that their ongoing medical treatment was stopped once the insurer or employer stopped paying for it on the basis of a

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[20] The Insurers' contention that *Doehr* added a historical prong to the *Mathews* test misreads the Court's opinion and is unsupportable. The Court in *Doehr* cited to historical evidence to bolster the determination it had *already made* that due process had been violated by the lack of notice or pre-deprivation process. It was not a predicate of the decision. The Court was in effect stating that not only is the lack of notice and opportunity to be heard in these circumstances unconstitutional today, under modern conceptions of due process, it has always been unconstitutional. The same can be said of the statute here.

[21] The Pennsylvania statute precludes a medical provider from accepting payment for medical treatment for or on behalf of an injured worker. Accordingly, injured workers are medical captives until the utilization review process is completed. *Cf., West v. Atkins*, 487 U.S. 42 (1988); *See also Sullivan*, App. at 16a.

utilization review request.[22] These benefits are public benefits and the state has exclusive control over the resolution of disputes among the parties in the administration of those benefits. The procedures so utilized must satisfy due process. *Logan v. Zimmerman Brush*, 455 U.S. at 429 n. 5. The insurers' insistence that medical bills in this context are like car insurance is simply wrong.[23]

Moreover, the Insurers' contention that a split in the circuits warrants this Court's review is without merit. The extent to which due process attaches to workers' compensation schemes in the various states, as well as the extent to which process is due, depend upon the structure and procedures pertinent to each statute.[24] There can be

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[22] This assertion must be taken as true since this case came before the court on a dismissal pursuant to F.R.C.P. 12(b)(6).

[23] The record in this case reveals that the utilization review system was specifically designed *not* to resemble a private insurance model.

[24] The cases cited by the Insurers to exemplify their "split in the circuits" only serve to demonstrate why each statute must be analyzed according to its own terms. *Cryder v. Oxendine*, 24 F.3d 175, 178 (11th Cir. 1994), involved a statute which gave the injured worker ten days advance notice that benefits would be terminated. There was no discussion by the court as to whether this notice was adequate under the due process clause, and in particular the requirements set forth in *Memphis Light*, because it was not challenged by the injured worker. *Sauceda v. Department of Labor and Industry*, 917 F.2d 1216 (9th Cir. 1990), involved a system in which the injured worker received a notice of impending termination along with a statement of reasons for the decision and the information that he had sixty days to protest or to seek reconsideration. Not only do these cases demonstrate that each state statute is different, but they directly refute the Insurers' contention that due process is not generally afforded by other state statutes prior to the

no declaration from this Court that all workers' compensation statutes in every state must comply with the same procedures in order to pass constitutional muster, or, as the Insurers would have it, that no workers' compensation statute can require prior notice and opportunity to be heard before benefits can be stopped. On the facts of this particular case, given the exclusiveness of the state's control over the administration of the system, the clarity of the public nature of the benefits at issue, and the fact that those benefits constitute constitutionally protected property, the Third Circuit's decision that the utilization review procedures are constitutionally deficient for their failure to accord pre-deprivation notice or opportunity to be heard of any kind was correct. A "legislature ... may not constitutionally authorize the deprivation of a [property] interest, once conferred, without appropriate procedural safeguards". *Logan*, 455 U.S. at 432. Review should therefore be denied.

III. CONCLUSION

For all the reasons stated herein, Respondents respectfully request that the Petitions of the Insurers and the School District for Writ of Certiorari be denied.

Respectfully submitted,

Loralyn McKinley
Counsel of Record
McKinley and Vonier
1333 Race Street
Philadelphia, PA 19107
(215) 569-1644

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termination of benefits.

(5)

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No. 97-2000

In the Supreme Court of the United States

OCTOBER TERM, 1997

AMERICAN MANUFACTURERS MUTUAL INSURANCE COMPANY, ET AL., PETITIONERS

v.

DELORES SCOTT SULLIVAN, ET AL., RESPONDENTS

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Third Circuit

REPLY BRIEF FOR PETITIONERS

ROBERT MCL. BOOTE
BURT M. RUBLIN
Ballard Spahr Andrews & Ingersoll, LLP
1735 Market Street
Philadelphia, PA 19103
(215) 665-8500

Counsel for All Petitioners Except Donegal Mut. Ins. Co.

ROBERT E. KELLY, JR.
Duane, Morris, Hecksher LLP
305 N. Front Street
Harrisburg, PA 17108
(717) 237-5500

Counsel for Donegal Mut. Ins. Co.

MICHAEL W. MCCONNELL
Counsel of Record
ALAN E. UNTEREINER
STEFFEN N. JOHNSON
SHARON SWINGLE
Mayer, Brown & Platt
190 South La Salle Street
Chicago, IL 60603
(312) 782-0600

Counsel for All Petitioners

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REPLY BRIEF FOR PETITIONERS

While respondents labor to portray this case as a "parochial dispute" affecting only the Commonwealth of Pennsylvania (Opp. 7), the practical and doctrinal significance of the decision below cannot seriously be denied. Respondents do not (and cannot) deny that at least 43 states, and the federal government, have cost containment measures similar, if not identical, to the utilization review procedure at issue in this case. See Pet. 15 n.6, 24-25. Nor do they dispute that the Third Circuit's decision renders that procedure all but useless, and effectively transfers regulatory authority over workers' compensation insurance from state legislatures to federal courts. Their attempts to distinguish conflicting lower court cases border on the frivolous. In short, respondents' brief confirms that this case warrants Supreme Court review.

I. THE STATE ACTION ISSUE

A. *The Merits*. We will not respond in detail to respondents' argument on the merits (Opp. 10-15). It rests largely on the dubious proposition that payments by a private insurance company to satisfy the legal obligations of a private employer to its injured workers are, in fact, "public benefits" akin to welfare or Social Security. See *id.* at 5, 7, 8-9, 13, 14; see also *id.* at 14 n.8 (referring to the Commonwealth's "constitutional and statutory duty to provide benefits"). The fallacy in that characterization was explained in the Petition (at 10-11): workers' compensation benefits are *mandated by the state*, but they are not *obligations of the state*. For state action purposes, they are analogous to insurance payments to satisfy a private party's tort liability. Indeed, it is precisely because the Third Circuit has obliterated the fundamental distinction between a system of benefits funded and distributed by the government and a system of regulated private benefits that the decision below warrants review.

It is telling that respondents do not even attempt to refute our showing (Pet. 12-14) that the decision below conflicts with this Court's decisions in *Jackson* v. *Metropolitan Edison Co.*, 419 U.S. 345 (1974); *Blum* v. *Yaretsky*, 457 U.S. 991 (1982); and *Rendell-Baker* v. *Kohn*, 457 U.S. 830 (1982). In fact, they neglect to mention *Jackson* or *Rendell-Baker*. They include *Blum* in a string

cite, with no attempt to distinguish it (Opp. 11). We take it, then, that respondents concede the conflict with these three precedents.

Rather than addressing these conflicts, respondents rely on the proposition that this Court has not prescribed any "formulaic and rigid approach to state action" and that state action decisions are necessarily "fact-bound." Opp. 11-12. But the necessarily fact-bound context of state action issues does not imply that lower courts are free to dispense with any rigorous analysis. If that were true, this Court should never grant certiorari in any state action case. Respondents' only attempt to provide an analytical structure for the state action question (*id.* at 12) is based on a three-part test extracted from this Court's decision in *Edmonson* v. *Leesville Concrete Co.*, 500 U.S. 614 (1991), *on which the Third Circuit did not rely*. That is tantamount to confessing that the Third Circuit offered "no coherent theory of state action" to justify its decision (see Pet. 12). As we stated in the Petition, this Court's review is needed to bring greater clarity and coherence to this important area of constitutional law. The Brief in Opposition unintentionally confirms the need for that guidance.

B. *Conflicts Among The Lower Courts*. In the Petition, we documented direct conflicts on the state action question with four federal courts of appeals as well as the state courts of Pennsylvania. Pet. 14-20. Respondents call this "baseless" (Opp. 15) and an "attempt to fabricate a conflict" (*id.* at 6). Yet their reasons are as weak as their rhetoric is strong.

First, noting that three of the four federal appellate decisions that conflict with the decision below were unpublished, respondents assert that it is "highly improper to argue that [unpublished decisions] establish a conflict in the circuits that warrants this Court's review." Opp. 16. Far from being "highly improper," however, this is in accord with this Court's practice. Cases in which this Court has granted certiorari to resolve conflicts involving unpublished opinions are legion. Recent examples include: *Commissioner* v. *Lundy*, 516 U.S. 235, 238-39 (1996); *Wooddell* v. *Int'l Bhd. of Elec. Workers*, 502 U.S. 93, 96 & n.2 (1991); *Wisconsin Pub. Intervenor* v. *Mortier*, 501 U.S. 597, 604 (1991); *Exxon Corp.* v. *Central Gulf Lines, Inc.*, 500 U.S. 603, 606-07 & n.4 (1991); *Lytle* v. *Household Mfg., Inc.*, 494 U.S. 545, 550 & n.2 (1990); *Doe* v. *United States*, 487 U.S. 201, 206 n.4 (1988); *Kentucky* v. *Graham*, 473 U.S. 159, 163 & n.6 (1985).

Second, they argue that, "[b]y definition," there "can be no conflict among the circuits in a case such as this" (Opp. 7) because the decisions arise under the workers' compensation laws of different states. This argument obviously proves too much: if it were true, this Court would never grant certiorari in a case involving the constitutionality of a state law. State laws are always different.

The real question is whether the state laws under review in these cases are different in any material respect. The state laws in all of the cases share a crucial characteristic: they authorize private insurance companies (and self-insured employers) to postpone payment of disputed workers' compensation bills until after investigation to determine whether the expense was legitimate. In all cases, this delay was permitted, but neither encouraged nor required, by the state. That is why the district court discussed and relied on all three of the four decisions that had been rendered by the time of its opinion, finding no significant points of distinction (Pet. App. 56a-58a).

If respondents wish to contend that the conflict is "baseless," they are under an obligation to identify differences in the statutory schemes that would produce a different result. This they fail to do. As to two of the decisions — *Grenz* v. *EBI/Orion Group, Inc.*, 1992 WL 158158 (9th Cir. July 9, 1992), and *Fleming* v. *Workers' Compensation Comm'n*, 1996 U.S. App. LEXIS 3858 (4th Cir. Mar. 5, 1996) — respondents do not even attempt to identify any relevant difference. Their purported distinctions of the other two decisions do not withstand analysis.

Respondents suggest (Opp. 17 n.12) that *Stanescu* v. *Aetna Life and Casualty Ins. Co.*, 1996 WL 466648 (2d Cir. Aug. 16, 1996), "cannot be seriously compared to *Sullivan*" because (1) "the injured workers in that case relied solely upon the exclusivity of workers' compensation for work injuries in Connecticut as their predicate for state action" and (2) "there was no interdependence between the insurers and the state and there was no state review of any kind." Neither point is correct. First, as the Second Circuit

pointed out, the workers in *Stanescu* invoked not just exclusivity but "joint participation" between the insurer and the State as a basis for finding state action. 1996 WL 466648, at *2. They also argued that the insurer was a state actor because it "was subject to pervasive State regulation pursuant to the Workers' Compensation Act and because [it] intentionally used the procedures established under that regulatory scheme to deny [the plaintiffs] workers' compensation benefits and medical treatment." *Stanescu* v. *Aetna Life and Casualty Ins. Co.*, No. 3:95CV356, slip op. 4 (D. Conn. Dec. 13, 1995). Second, there was no less "interdependence" between the insurer and the state in *Stanescu* than in this case. To suspend payments under the provision of Connecticut law at issue in *Stanescu*, the insurer was required to file a report containing "all information supporting [its] claim" with a state agent, who had authority to accept or reject it. Conn. Gen. Stat. § 31-349 (West 1995). If anything, this suggests a *greater* degree of state involvement than in this case, where the insurer's filing with the state is reviewed only for formal completeness.

Respondents summarize the Third Circuit's purported reasons for distinguishing *Barnes* v. *Lehman*, 861 F.2d 1383 (5th Cir. 1988). Opp. 17 n.13. But as we discussed in detail in the Petition (at 16-17), these purported differences were "either based on a misunderstanding of Texas law or irrelevant to the state action issue." Respondents do not even attempt to respond to our arguments.

Respondents maintain that the conflict between the Third Circuit and the state courts of Pennsylvania has disappeared because a subsequent decision of the Pennsylvania Supreme Court contained language seemingly at odds with the earlier decision. Opp. 18 n.14. The later case, *Bible* v. *Commonwealth of Pennsylvania*, 696 A.2d 1149 (Pa. 1997), however, did not involve a state action issue. The question presented in *Bible* was whether retroactive changes in workers' compensation benefit amounts violate the state constitution's equivalent of the Contracts Clause. The court held that they do not, because the benefit levels are not contractual in nature. That holding has no bearing on whether the actions of private insurance companies within the discretion left to them under the statutory scheme should be deemed to be state action. The conflict between the state courts and the Third Circuit created

by *Baksalary* v. *Smith*, 579 F. Supp. 218 (E.D. Pa. 1984), appeal dismissed, 469 U.S. 1146 (1985), and deepened by the Third Circuit's decision below, still exists. Pennsylvania decisions subsequent to *Baksalary* have, perforce, acknowledged the authority and effect of the federal ruling, but have not accepted the correctness of its reasoning on the state action question or applied that reasoning to other contexts.[1]

C. *Practical and Doctrinal Significance*. The Third Circuit's state action holding is of doctrinal importance far beyond the context of workers' compensation. The Third Circuit's logic — that private insurers become state actors when they are subject to extensive regulation, a mandate to provide benefits, state dispute resolution, and filing requirements — could apply to a wide range of benefit plans regulated at the federal or state level,[2] as well as a host of other regulated industries in which the government mandates service.

II. THE DUE PROCESS ISSUE

As we explained in the Petition, the due process holding of the court below would overturn the law and traditional practice of almost every state and the federal government, would make it extremely difficult to protect against fraud and abuse by medical providers, and would cast doubt on the constitutionality of utilization review in a wide variety of contexts. Respondents do not

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[1] See, *e.g.*, *Williams* v. *Workmen's Compensation Appeal Bd.*, 562 A.2d 437, 439 n.3 (Pa. Commw. Ct. 1989); *Kinter* v. *Workmen's Compensation Appeal Bd.*, 579 A.2d 1010, 1011 n.2 (Pa. Commw. Ct. 1990); *Moore* v. *Workmen's Compensation Appeal Bd.*, 676 A.2d 690, 694 (Pa. Commw. Ct. 1996); *Warminster Fiberglass* v. *Workers' Compensation Appeal Bd.*, 708 A.2d 517, 519-20 n.4 (Pa. Commw. Ct. 1998).

[2] See, *e.g.*, *Grijalva* v. *Shalala*, ___ F.3d ___, 1998 WL 467102, *4 (9th Cir. Aug. 12, 1998) (concluding, based on reasoning similar to that adopted by the Third Circuit, that HMOs administering Medicare benefits are state actors); *Kreschollek* v. *Southern Stevedoring Co.*, Civ. No. 93-9303, slip op. 5-7 (D.N.J. Sept. 30, 1997) (applying a similar analysis and holding that self-insured employers paying benefits under the federal Longshore and Harbor Workers' Compensation Act are state actors).

dispute any of these points. The arguments they do make, moreover, are wholly without merit. We will discuss those that pertain to our petition in the order presented.

A. *Mootness*. First, respondents contend that the due process issue is moot because the Commonwealth has already modified its procedures to rectify the supposed due process problem and is not seeking review of the opinion below. Opp. 18-19. In fact, the Commonwealth filed a conditional cross-petition challenging the due process holding on July 10, 1998. Counsel for respondents were well aware when they wrote the Brief in Opposition that the Commonwealth intended to file the cross-petition, having been informed of that fact by counsel for the Commonwealth as well as by counsel for these petitioners.

Even if the Commonwealth had not filed a petition for certiorari, respondents' mootness argument would still be erroneous. Although respondents are correct that the Pennsylvania Bureau of Workers' Compensation has modified the forms required to initiate utilization review, and thus satisfied the requirements of the decision below that pertain to notice, petitioners have not sought review of that aspect of the Third Circuit's decision. Pet. 22 n.12. The petition is confined to the most significant issue in the case: the right of insurers (and self-insured employers) to postpone payment of disputed claims pending utilization review. The Third Circuit struck from the statute the authorization for delay of payment in disputed cases, Pet. App. 25a,[3] and no action by the Bureau could possibly render that portion of the decision moot. Furthermore, the petitioners are still subject to respondents'

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[3] The statute, in the form passed by the legislature, provided in relevant part:

> All payments to providers for treatment provided pursuant to this act shall be made within thirty (30) days of receipt of such bills and records *unless the employer or insurer disputes the reasonableness or necessity of the treatment provided pursuant to paragraph (6).*

77 Pa. Cons. Stat. Ann. § 531(5) (West 1997) (emphasis added). The Court of Appeals severed the italicized portion of the statute, leaving insurers with the obligation to pay disputed claims before utilization review could take place.

claims for damages and injunctive relief based on the Third Circuit's ruling.

B. *Conflicts With* Doehr *And Among The Lower Courts*. In the Petition, we showed that the decision below was inconsistent in two important respects with this Court's decision in *Connecticut* v. *Doehr*, 501 U.S. 1 (1991). First, *Doehr* held that analysis of due process requirements must be informed by a review of "[h]istorical and contemporary practices." *Id.* at 16-17.[4] Respondents' cursory denial (Opp. 28 n.20) that *Doehr* requires this reference to established practices ignores the express directive in that case. The Third Circuit's opinion flagrantly violates that principle, by failing to give the practices of Pennsylvania and virtually all other states any weight in its analysis.

Second, *Doehr* held that in a case involving disputes between private parties, the standard due process analysis must be altered to take the interests of *both* private parties into account (rather than just the plaintiff's interest and the governmental interest). 501 U.S. at 10-11. Even though it acknowledged the insurers' argument that their property interest must also be considered (Pet. App. 27a), the Third Circuit then conducted the due process balancing test without reference to the private interests of the employers or insurers, in violation of the teaching of *Doehr*. See *id.* at 28a (concluding that "the employees' private interest" is "a weighty and significant factor in the * * * calculus" without mentioning the insurers' interest); *id.* at 30a (concluding that "the private interest" of employees is not outweighed by "any governmental interest," again without mention of any other private interest). Respondents thus mischaracterize the holding below as taking insurer interests into account. The lower court's failure to do so was especially significant since, by law, an insurer can never recover payments once made to a provider and thus irrevocably forfeits its property interest.

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[4] That was not a novel holding. See, *e.g.*, *Burnham* v. *Superior Court*, 495 U.S. 604, 621-22 (1990) (opinion of Scalia, J.); *Schall* v. *Martin*, 467 U.S. 253, 268 (1984); *In re Winship*, 397 U.S. 358, 361-62 (1970); *Leland* v. *Oregon*, 343 U.S. 790, 798 (1952).

Respondents have even less of relevance to say about the conflicts with other federal courts of appeals. See Opp. 29 n.24. To be sure, in *Cryder* v. *Oxendine*, 24 F.3d 175 (11th Cir. 1994), and *Sauceda* v. *Dep't of Labor & Indus.*, 917 F.2d 1216 (9th Cir. 1990), the injured workers received more notice that the insurers were delaying payment of bills pending further review (see Opp. 29 n.24). But the issue here is not the Third Circuit's notice requirement — which petitioners are not contesting — but the separate requirement that provider bills be paid before utilization review. The relevant conflict is that in *Cryder* and *Sauceda*, the Eleventh and Ninth Circuits held that it does not violate due process for workers' compensation insurers to suspend payments pending review of the validity of the claim. Respondents have nothing to say about that.

C. *The Merits.* Most of what respondents say about the merits of the due process issue is based on confusing prospective medical care with the payment of bills. This distinction is critical for due process purposes. The Third Circuit's holding extends *Mathews* v. *Eldridge*, 424 U.S. 319 (1976), far beyond its traditional application, where a plaintiff suffers a direct deprivation, to a challenged practice that directly affects only a third party supplier to the plaintiff. The significant due process issue presented by this case is whether *Mathews* applies to conduct that, at best, has an indirect and uncertain effect on the private interests of the plaintiff.

Respondents claim that we mischaracterize the case as a mere dispute over bills, when it really involves decisions to cease future medical treatment. This assertion is contradicted by the very text of the statutory provision struck down by the Third Circuit, which applies only to bills received for medical treatment already provided: "[a]ll payments to providers for treatment provided pursuant to this act shall be made within thirty (30) days of receipt of such bills and records unless the employer or insurer disputes the reasonableness or necessity of the treatment provided pursuant to paragraph (6)." 77 Pa. Cons. Stat. Ann. § 531(5) (West 1997). Thus, it is not petitioners who "characteriz[e] the dispute as one over 'bills'" (Opp.9); the statute itself uses this terminology.

Respondents assert that a delay in payment of medical bills is tantamount to a cessation of medical care. See Opp. 28 ("Unless

the doctor or other medical provider agrees to work gratuitously, once payments stop, so does the treatment") (footnote omitted). But the prospect of utilization review does not mean that providers must provide health care "gratuitously." Any medical provider who is in compliance with "generally accepted treatment protocols" (34 Pa. Code § 127.467) can expect to be paid in full, with interest, in approximately 70 days. Only those providers who are aware that their treatment is unlikely to be deemed reasonable and necessary by a disinterested professional in their own specialty will have reason to cease treatment. And even then, an employee may choose to pay out-of-pocket for continued care and would later be reimbursed if that treatment were found to be reasonable and necessary.[5] Contrary to respondents' description of the facts of the case (see Opp. 1 ("Respondents all are injured workers who have had their medical benefits stopped"); *id.* at 2 (respondents "were ten individuals who have had their medical benefits stopped through a request for utilization review")), at least six of the ten named respondents continued to receive medical care for some period of time after an employer or insurer petitioned for utilization review and suspended payment, C.A. App. A99, A100, A105, A107, A108, A113. In this respect, workers' compensation insurance works in the same way as any other fee-for-service insurance system. No one claims that a patient is "denied medical care" because his bill may be investigated prior to payment by the insurance company. The real targets of utilization review are not the injured workers, but unscrupulous medical care providers who provide unnecessary and unreasonable services to workers.

Respondents also assert that compliance with the Third Circuit's decision can be accomplished "without significant difficulty or expense." Opp. 4; see also *id.* at 24. Actual experience is to the contrary. The primary impetus for the 1993 legislative reforms was the extraordinary rise in the cost of medical coverage under workers' compensation after the decision in

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[5] Although a provider denied reimbursement under the Workers' Compensation Program may not subsequently attempt to collect from the employee, see 77 Pa. Cons. Stat. Ann. § 531(7), the employee is not prohibited from contracting for care that falls outside the statutory scheme. At least one of the respondents did precisely that. See C.A. App. A113.

Baksalary (a similar decision under a prior version of the statute). After the *Baksalary* court held that workers' compensation insurers could not suspend benefit payments pending administrative review, the number of documented cases of payments for unnecessary and unreasonable medical bills rose from $1.6 million to over $25.2 million — an increase of 1500%. D. BALLANTYNE & C. TELLES, WORKERS' COMPENSATION IN PENNSYLVANIA: ADMINISTRATIVE INVENTORY 39 (1991); D. BALLANTYNE, REVISITING WORKERS' COMPENSATION IN PENNSYLVANIA: ADMINISTRATIVE INVENTORY 72 (1997). Of the cases submitted to utilization review, even with a statutory presumption in favor of payment, some 67% of disputed bills have been found to be unreasonable or unnecessary in whole or in part. Letter from Timothy Wisecarver, President, Pennsylvania Compensation Rating Bureau, to Richard Himler, Director, Pennsylvania Bureau of Workers' Compensation (July 1, 1993) (reproduced in Appendix to the *Amicus Curiae* Brief of American Insurance Ass'n, et al.) Because insurers cannot by law recover payments of these bills once made, the ruling below would have a dramatic effect on the cost of Pennsylvania's workers' compensation system.

The importance of this case, both for the workers' compensation system and for analogous health care payment systems under state and federal law, is underscored by the broad array of parties who have filed *amicus curiae* briefs urging the Court to take this case for review. This puts into perspective respondents' plea (Opp. 7) that certiorari should be denied because the decision below will have no impact outside of the workers' compensation scheme in the Commonwealth of Pennsylvania.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted.

ROBERT MCL. BOOTE
BURT M. RUBLIN
Ballard Spahr Andrews & Ingersoll, LLP
1735 Market Street
Philadelphia, PA 19103
(215) 665-8500

Counsel for All Petitioners Except Donegal Mut. Ins. Co.

ROBERT E. KELLY, JR.
Duane, Morris, Hecksher, LLP
305 N. Front Street
Harrisburg, PA 17108
(717) 237-5500

Counsel for Donegal Mut. Ins. Co.

MICHAEL W. MCCONNELL
Counsel of Record
ALAN E. UNTEREINER
STEFFEN N. JOHNSON
SHARON SWINGLE
Mayer, Brown & Platt
190 South La Salle Street
Chicago, IL 60603
(312) 782-0600

Counsel for All Petitioners

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IN THE
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OCTOBER TERM, 1997

AMERICAN MANUFACTURERS MUTUAL INSURANCE COMPANY, *et al.*,
Petitioners,

v.

DOROTHY SCOTT SULLIVAN, *et al.*,
Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Third Circuit

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BRIEF OF *AMICI CURIAE* AMERICAN INSURANCE ASSOCIATION, ALLIANCE OF AMERICAN INSURERS, NATIONAL ASSOCIATION OF INDEPENDENT INSURERS, INSURANCE FEDERATION OF PENNSYLVANIA, STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY, NATIONAL ASSOCIATION OF MANUFACTURERS, NATIONAL COUNCIL OF SELF-INSURERS, UWC-STRATEGIC SERVICES ON UNEMPLOYMENT COMPENSATION & WORKERS' COMPENSATION, PENNSYLVANIA MANUFACTURERS' ASSOCIATION, PENNSYLVANIA SELF-INSURERS' ASSOCIATION, PENNSYLVANIA DEFENSE INSTITUTE AND PENNSYLVANIA RETAILERS' ASSOCIATION IN SUPPORT OF THE PETITION

MARK F. HORNING
Counsel of Record
SHANNEN W. COFFIN
STEPTOE & JOHNSON LLP
1330 Connecticut Avenue, N.W.
Washington, D.C. 20036
(202) 429-8126
Counsel for *Amici Curiae*

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MISCELLANEOUS:

A. Fehn, *Are We Protected from HMO Negligence?: An Examination of Ohio Law, ERISA Preemption, and Legislative Initiatives*, 30 AKRON L. REV. 501 (Summer 1997)	19
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P. Mihaly, *Health Care Utilization Review: Potential Exposures to Negligence Liability*, 52 OH. ST. L.J. 1289 (1991)	19
R. VICTOR, J. GARDNER, D. SWEENEY & C. TELLES, WORKERS COMPENSATION RESEARCH INSTITUTE, COST DRIVERS IN SIX STATES (1992)	15
R. Conrad, Jr. & P. Seiter, *Health Plan Liability in the Age of Managed Care*, DEFENSE COUNS. J., Apr. 1995, at 191	19
S. ECCLESTON & C. YEAGER, WORKERS COMPENSATION RESEARCH INSTITUTE, MANAGED CARE AND MEDICAL COST CONTAINMENT IN WORKERS' COMPENSATION, A NATIONAL INVENTORY, 1997-1998 (1997)	15, 16

IN THE

Supreme Court of the United States

OCTOBER TERM, 1997

No. 97-2000

AMERICAN MANUFACTURERS MUTUAL INSURANCE COMPANY, *et al.*,
Petitioners,

v.

DOROTHY SCOTT SULLIVAN, *et al.*,
Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Third Circuit

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BRIEF OF *AMICI CURIAE* AMERICAN INSURANCE ASSOCIATION, *ET AL.*, IN SUPPORT OF THE PETITION

INTEREST OF THE *AMICI*

Amici curiae respectfully submit this brief in support of the petition for writ of certiorari to the Third Circuit.[1] *Amici curiae* American Insurance Association, Alliance of American Insurers and National Association of Inde-

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[1] Pursuant to Supreme Court Rule 37.6, *amici curiae* state that no counsel for any party to this dispute authored this brief in whole or in part and no person or entity, other than *amici curiae* and their member companies, made a monetary contribution to the preparation or submission of this brief. Most of the private insurer petitioners are members of one of the *amici* insurance industry trade associations.

pendent Insurers are national insurance industry trade associations and Insurance Federation of Pennsylvania is a state insurance trade association whose member companies write a substantial portion of the workers' compensation insurance policies in Pennsylvania, the state in which this case arose. *Amicus curiae* State Farm Mutual Automobile Insurance Company is an insurance company that writes automobile and homeowners' insurance in Pennsylvania and throughout the country. *Amici curiae* National Association of Manufacturers, National Council of Self-Insurers, UWC-Strategic Services on Unemployment Compensation & Workers' Compensation, Pennsylvania Manufacturers' Association, Pennsylvania Self-Insurers' Association, Pennsylvania Defense Institute, and Pennsylvania Retailers' Association are all trade or advocacy organizations that, among other things, represent the interests of employers.

Amici have a substantial interest in supporting the petition for certiorari for two reasons. *First*, the appellate court's decision subjects insurers and self-insured employers to liability as state actors for administering claims arising under their private contracts of workers' compensation insurance or self-insurance plans. The holding below thus would require insurers and self-insurers to adopt burdensome adjudicative-type procedures for resolution of claims disputes not required by their agreements or state regulatory law.

Second, the Third Circuit ruling strikes down an important legislative reform of the workers' compensation system in Pennsylvaia and threatens to undo similar reforms in other states. The costs of the medical care component of workers' compensation benefits experienced geometric growth in the 1980's and early 1990's. In response, many states enacted legislation to contain the costs of medical care, including enhanced employer and insurer authority over the delivery of medical treatment. One dimension of this authority was stronger "utilization review" measures to determine the reasonableness and

necessity of medical treatment for injured employees. The lower court's decision would seriously impair these reforms by rendering utilization review ineffective as a means of combating fraud and unnecessary treatment by medical care providers.

Due to *amici*'s familiarity with the workers' compensation system of the various states and the role of private insurers and self-insured employers in it, this brief addresses the potentially significant implications of the Third Circuit's decision for insurers and employers.[2]

SUMMARY OF ARGUMENT

State Action Issue: The Third Circuit's state action holding should be reviewed because it would broadly extend the requirements of the Due Process Clause to private insurers and self-insured employers, thereby creating a new federal system of constitutional insurance regulation in conflict with state regulation. Such a federal scheme is especially problematic in light of the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-15, in which Congress established a federal "hands-off" policy in insurance regulation.

The lower court viewed private workers' compensation insurers as performing a traditionally governmental function because they acted as an "arm" or "partner" of the state in administering a system of "public benefits." Pet. App. at 14a-15a. In fact, however, the benefits paid by an insurer under workers' compensation insurance policies do not fulfill any financial obligations of the state itself but rather the private contractual obligation of an insurer voluntarily electing to write coverage for the employer's risk of liability. In no sense, therefore, do workers' compensation insurers provide a service that traditionally has been the prerogative of the state. The lower court regarded claims payments under these policies as "public benefits" solely because insurers are extensively regulated and because the workers' compensation law is the "exclu-

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[2] All parties have consented to the filing of this brief, and letters of consent have been filed with the Office of the Clerk of this Court.

sive" remedy for insured workers. Under this rationale, virtually all of the claims-handling practices of private insurers would be transformed into state action regardless of whether the state actually mandated or actively encouraged the practice.

Moreover, because many states also extensively regulate other insurance markets and limit tort remedies (*e.g.*, under "no fault" automobile insurance laws), the decision below could force many other types of insurers to adopt quasi-adjudicative procedures for claims disputes that would impose significant new costs and potentially reduce the availability of private insurance.

Alternatively, the Third Circuit held that private insurers were state actors because they made informational filings with state regulators that were subject to ministerial review for completeness but not on the merits. However, many privately-initiated insurer practices must be described in filings with state regulators, in particular, rates and policy terms. Under the Third Circuit's decision, this private conduct would be transformed into state action irrespective of whether state regulators mandated the practice or affirmatively approved it after substantive review. The Third Circuit's alternative holding should thus be reviewed because it threatens to transform regulated insurers into state actors merely because of a regulator's acceptance of or acquiescence in a filing.

Due Process Issue: The Third Circuit's separate due process holding should be reviewed because it threatens to nullify numerous state reforms, over the past decade, seeking to contain the costs of medical care and thus to enhance the availability and affordability of insurance coverage. The Pennsylvania utilization review statute struck down in this case was designed to prevent overtreatment and fraud by medical care providers by allowing insurers and self-insured employers to obtain medical peer review of provider bills to determine whether treatment previously given to injured workers was reasonable and necessary. The appellate court's decision erroneously

assumed that an insurer's mere delay in paying a disputed bill, pending completion of utilization review, was tantamount to a cutoff of medical benefits to the injured worker—even though, in the cases affected by the statutory provisions in dispute, that worker already had received the disputed treatment. Based on this misconception, the appellate court required insurers to pay for the disputed treatment before the outcome of utilization review—at which point, any excessive payment previouly made to the provider cannot, for legal and practical reasons, ever be recovered. The lower court's decision should thus be reviewed because it calls into question the constitutional validity and effectiveness of numerous state utilization review statutes applicable not only to workers' compensation insurance but also to automobile, health and disability policies affording medical benefits.

ARGUMENT

I. THIS COURT SHOULD REVIEW THE THIRD CIRCUIT'S EXPANSIVE RULING THAT PRIVATE WORKERS' COMPENSATION INSURERS ARE "STATE ACTORS"

A. The Third Circuit Erroneously Concluded That Private Workers' Compensation Insurers Are "Arms" of the State

The Third Circuit considered workers' compensation insurers to be state actors for essentially two reasons. First, the court concluded that, "[a]lthough the insurance companies are private entities, when they act under the construct of the Workers' Compensation system, they are providing public benefits which honor State entitlements. In effect, they become an arm of the State, fulfilling a uniquely governmental obligation . . . ." Pet. App. at 14a-15a. Second, the lower court found that an insurer's mere notice to the Pennsylvania Bureau of Workers' Compensation ("Bureau") that it was initiating utilization review and the Bureau's review of the form for completeness amounted to active state encouragement of the insurer's unilateral decision to suspend payment of health care pro-

vider bills pending such review. *Id.* at 15a. These holdings reflect a fundamental misunderstanding of the workers' compensation system and the role of private insurers in it.

In Pennsylvania, as in other jurisdictions, the obligation to pay workers' compensation benefits falls upon employers. *See* 77 Pa. Stat. Ann. § 431. Thus, workers' compensation benefits are not a publicly-funded entitlement program like Social Security disability, Medicare or Medicaid.

Moreover, the coverage written by workers' compensation insurers is much the same as other types of third-party liability coverage that protects a policyholder, in this case the employer, against a potential legal liability, in this case liability for payment of lost wages and medical treatment caused by work-related accidents. Claims payments under workers' compensation policies are therefore no more of a "public benefit" than claims paid by insurers to other third parties as a result of legal liability (*e.g.*, claims paid to persons injured by an insured's negligence).

Nor does the workers' compensation law conscript insurers to administer benefits payments on behalf of the state and thus make the insurer a "partner or an arm of the State" in implementing the workers' compensation law. Pet. App. at 15a. Property casualty insurers are not required to write workers' compensation coverage; they unilaterally and voluntarily decide whether to write such coverage and can withdraw from the market at any time. Indeed, in the legislative debate which preceded passage of the 1993 reforms at issue in this case, one Pennsylvania House member argued that cost containment measures were necessary because "insurance companies, an awful lot of them in Pennsylvania, are refusing to write workers' compensation . . . [because] they cannot make a profit . . . ." Floor Statement of Rep. Fargo, Pa. House Journal at 547 (Mar. 30, 1993).

Nor is the state a joint decisionmaker with the insurer. The insurer alone makes decisions on underwriting and

implementing the terms of its contracts, including the investigation and payment of claims. The workers' compensation insurer thus performs the same private, commercial functions as other types of insurers.

Insurers' only relationship with the state is that they are subject to regulation. For example, they must be licensed to write workers' compensation insurance, the coverage afforded under a policy must include all benefits directed by statute, and the rates are approved by the Insurance Commissioner. *See* 77 Pa. Stat. Ann. § 997 (power of Commissioner to revoke workers' compensation insurance license); 77 Pa. Stat. Ann. §§ 1035.1 *et seq.* (workers' compensation insurance rating law). In these respects, workers' compensation insurance is no different from many other types of regulated policies, such as automobile insurance.

The Third Circuit's decision also reflects a basic misunderstanding of the state's involvement in the insurer's decision to invoke utilization review of provider bills and to suspend payment until the completion of review. The determination of eligibility for and payment of benefits is made by the insurance company itself as a matter of contract. When the worker is injured, the insurer must first make a determination whether the injury was occupationally related. It then reviews and pays the provider's medical bills.

The Commonwealth has only two types of involvement in this claims payment process. First, it regulates the type of benefits to be paid and the amount paid. For example, the 1993 legislation challenged here established a schedule of fees for various types of medical treatment. *See* 77 Pa. Stat. Ann. § 531(3). Second, the state creates various dispute resolution procedures—including utilization review—for disputes among employees, employers, insurers and medical care providers over entitlement to or amount of payment. Those procedures are designed to foster the private and informal resolution of these disputes.

The private insurer itself unilaterally determines whether to seek utilization review. The Commonwealth does not

initiate utilization review, mandate it or screen those cases best suited for such review. The insurer merely files a form with the Bureau notifying it of the insurer's decision to seek utilization review of disputed treatment. *See* Pet. App. at 5a. The Bureau then conducts a limited, non-substantive review to ensure that the form is properly completed. "The Bureau's review of the Initial Request does not address the legitimacy or lack thereof of the request for utilization review." *Id.*

Nor does the state lend any active encouragement to the insurer's decision to withhold payment of the provider bill pending utilization review. The insurer has the option, but is not required, to suspend payment to a provider immediately upon requesting utilization review with the Bureau. *See* Pa. Code § 127.208(e).

Once the insurer requests review, the utilization review panel is randomly selected from a roster of medical providers in the same profession or specialty as the provider whose treatment is under review. Pet. App. at 6a-7a. The providers are all private parties and not employees of the Commonwealth. No state official is involved in the utilization review process as a panelist, investigator or adjudicator, and panel members deal directly with the provider and the insurer. The state first becomes actively involved if the insurer, employer, employee or provider appeal the utilization review panel's decision to an administrative law judge. *See* 77 Pa. Stat. Ann. § 531(6)(iv); 34 Pa. Code § 127.208(f).

The utilization review procedure can thus be likened to a dispute where first mediation and then actual litigation ensue. The insurer first attempts to mediate the dispute with the provider by using private mediators, namely, the utilization review panelists. If the utilization review fails to resolve the dispute, the parties may litigate in an administrative law forum. It is only then that the Commonwealth becomes involved in the resolution of the dispute but does so only as an impartial factfinder. Prior to that stage, the decisions at issue—whether to dispute the

reasonableness and necessity of medical treatment and to suspend payment—are made solely by the private insurer.

The decision below should be reviewed because it significantly expands the "public function," "symbiotic relationship" and "active state encouragement" tests for determining whether the conduct of regulated private businesses can be attributed to the state. The payment of workers' compensation benefits under private contracts of insurance cannot be viewed as a governmental function. The test is whether the private enterprise is exercising "powers traditionally exclusively reserved to the State." *Jackson v. Metropolitan Edison Co.*, 419 U.S. 345, 352 (1974). Here, private insurers are not providing benefits that the state has an obligation to provide. *See Dillard v. Industrial Comm'n of Va.*, 416 U.S. 783, 798 (1974) (noting that funds used to pay workers' compensation benefits "are private, not public").

Nor does a private insurer become a "partner" of the state (*see* Pet. App. at 15a) and thus have a "symbiotic relationship" merely because it is subject to state regulation—even "extensive and detailed" regulation. *Jackson*, 419 U.S. at 350. Finally, Pennsylvania's mere acquiescence in the insurer's decision to seek utilization review and to delay payment in the meantime cannot constitute "active state assistance." As noted in *Blum v. Yaretsky*, 457 U.S. 991 (1982), "[m]ere approval of or acquiescence in the initiatives of a private party is not sufficient to justify holding the State responsible for those initiatives. . . ." *Id.* at 1004-05 (citations omitted); *see also Life Ins. Co. v. Reichardt*, 591 F.2d 499, 502 (9th Cir. 1979) (alleged discriminatory terms of disability insurance policy not product of state action despite the fact that form was approved by Commissioner of Insurance because "state does not command the discrimination," but merely performs "pro forma" review).

B. The Third Circuit's State Action Decision Has Broad Implications for a Variety of Insurance Coverages

Precisely because the lower court's state action decision was based primarily on the regulated status of workers' compensation carriers, its ruling has potentially broad implications for other workers' compensation insurance practices and other regulated insurance markets.

By broadly characterizing private workers' compensation insurers as an "arm" of the state in administering a program of "public benefits," the decision below has ramifications going far beyond utilization review. Insurers potentially could be treated as state actors in connection with *any* activity associated with the payment of benefits to injured workers. This might include, for example, the underwriting of policies that affects the ultimate availability of benefits; determinations whether injuries are occupationally related and thus eligible for benefits; and decisions affecting eligibility for disability (as opposed to medical) benefits (*e.g.*, termination of temporary total disability benefits upon a worker's recovery). In all of these instances, the insurer could be treated as a state actor, under the Third Circuit's rationale, without receiving any active assistance from a state official. Moreover, application of the lower court's state action rationale threatens to subject insurers to constitutional constraints under other provisions of the Constitution as well. For instance, insurers could be required to guarantee equal protection to their policyholders and beneficiaries. The decision below thus threatens to create an entirely new system of federal constitutional requirements and remedies for insurance policy disputes on top of the contractual and administrative remedies created under state law. This result would be antithetical to the policy of federal deference to state insurance regulation. *See* McCarran-Ferguson Act, 15 U.S.C. §§ 1011-15.

The group most immediately affected by the Third Circuit's ruling, other than workers' compensation insurers,

are self-insuring employers. Self-insured employers perform most of the same functions as insurers and are subject to much of the same regulation. The appellate court's decision thus would treat *all* types of private businesses, in their capacity as employers, as state actors, not just insurers.

The Third Circuit's state action rationale might also extend to other regulated insurance markets. This is because, in concluding that workers' compensation insurers are state actors, the lower court relied heavily upon three characteristics of Pennsylvania's workers' compensation scheme which are common to many types of insurance coverage.

First, the court relied on the fact that the workers' compensation system is an "exclusive remedy": "an employee cannot opt-out of Pennsylvania Workers' Compensation scheme." Pet. App. at 14a. Second, the court noted that Pennsylvania imposes "a statutory obligation upon the employer to pay for all work-related injuries of his/her employees," which must be satisfied either by insurance or self-insurance. *Id.* at 14a n.18. Third, the court emphasized that the "Commonwealth has enacted a complex and interwoven regulatory web enlisting the Bureau, the employers, and the insurance companies." *Id.* at 14a. These three characteristics—the substitution of a statutory remedy for common law remedies, a mandate to purchase insurance, and extensive regulation—are common to many types of insurance.

There are, for example, numerous state and federal law mandates that private parties purchase insurance coverage. For example, all fifty states and the District of Columbia require automobile drivers to post financial security in order to operate a motor vehicle, usually by mandating the purchase of automobile liability insurance.[3] Many states

[3] Ala. Code § 32-7-6; Alaska Stat. §§ 28.22.011, 28.22.101; Ariz. Rev. Stat. §§ 28-4009, 28-4135; Ark. Code Ann. §§ 27-22-103, 27-22-104; Cal. Veh. Code §§ 16020-16021; Col. Rev. Stat. § 10-4-705;

require companies engaged in the business of remediating pollution from underground storage tanks to provide evidence of financial responsibility, which may be in the form of insurance or self-insurance. *See, e.g.*, 35 Pa. Stat. Ann. § 6021.701; N.J. Stat. Ann. §§ 58:10A-24.3, 58:10A-24.4(b). In federal law, the Price-Anderson Act requires that licensed nuclear facility operators obtain the maximum amount of liability insurance available from private sources. 42 U.S.C. § 2210(b). The Miller Act requires federal government contractors to post surety bonds for the performance of their construction contracts. *See* 40 U.S.C. §§ 270a-270d.

Similarly, many states have substituted an "exclusive" statutory remedy for tort liability.[4] The best examples

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Conn. Gen. Stat. § 38a-371; Del. Code Ann. tit. 29, §§ 2902, 2948; D.C. Code Ann. §§ 35-2103, 35-2106; Fla. Stat. Ann. §§ 627.733, 627.736; Ga. Code Ann. § 33-4-5; Haw. Rev. Stat. §§ 431:10C-104, 431:10C-301; Idaho Code §§ 49-1209, 49-1212; 625 Ill. Comp. Stat. 5/7-601; Ind. Code Ann. §§ 9-25-4-1 through 9-25-4-5; Iowa Code § 321A.5; Kan. Stat. Ann. § 40-3104; Ky. Stat. Ann. § 304.39-080; La. Rev. Stat. Ann. § 32:861; Me. Rev. Stat. Ann. tit. 29, § 1601; Md. Transp. Code Ann. §§ 17-103, 17-104; Mass. Ann. Laws ch. 90, §§ 34A-34B; Mich. Stat. Ann. § 24.13101; Minn. Stat. § 65B.48; Miss. Code Ann. § 63-15-11; Mo. Rev. Stat. § 303.025; Mont. Code Ann. § 61-6-301; Neb. Rev. Stat. Ann. § 60-508; Nev. Rev. Stat. Ann. § 485.185; N.H. Rev. Stat. Ann. § 264:3; N.J. Stat. Ann. § 39:6A-3; N.M. Stat. Ann. § 66-5-205; N.Y. Veh. & Traf. Law § 312; N.C. Gen. Stat. § 20-279.5; N.D. Cent. Code § 39-08-20; Ohio Rev. Code Ann. §§ 4509.19, 4509.20; Okla. Stat. tit. 7, § 601; Or. Rev. Stat. § 806.010; 75 Pa. Cons. Stat. § 1305; R.I. Gen. Laws § 31-31-6; S.C. Code Ann. § 56-9-450; S.D. Codified Laws § 32-35-113; Tenn. Code Ann. § 55-12-105, 55-12-106; Tex. Transp. Code Ann. § 601.051; Utah Code Ann. § 41-12a-301; Vt. Stat. Ann. tit. 23, § 800; Va. Code Ann. §§ 46.2-435, 46.2-436; Wash. Rev. Code §§ 46.29.060, 46.29.080; W. Va. Code § 17D-2A-3; Wis. Stat. §§ 344.14, 344.15; Wyo. Stat. Ann. § 31-9-202.

[4] At the federal level, at least one federal district court has applied reasoning similar to the Third Circuit in this case to conclude that self-insured employers paying federal workers' compensation benefits under the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. §§ 901-950 ("LHWCA"), are state actors. *See Kreschollek v. Southern Stevedoring Co.*, Civ. No. 93-3903,

are automobile liability laws which, like workers' compensation laws, substitute a "no fault" compensation standard for previously-available tort remedies.[5] And, of course, most lines of property/casualty insurance—including automobile, homeowners' and commercial property and liability—are subject to an extensive administrative system of regulation governing rates, underwriting, policy terms and claims payments.

The Third Circuit's expansive state action test threatens to convert private insurers into state actors in each of these situations. Under the lower court's rationale, the mere fact that the policyholder is required to buy insurance or that its statutory remedies are exclusive would make the regulated insurer an "arm" of the state in administering an "exclusive" system of "public benefits." Private insurance contracts would become a state entitlement requiring the insurer to treat claimants as if they were beneficiaries of public funds.

In particular, the Third Circuit's finding of state action based on an insurer's filing with a state regulator has potentially broad ramifications. As regulated companies, insurers frequently are called upon to make informational, notice and other filings with state regulators. They must, for example, file rates and policy forms. *See, e.g.*, 77 Pa. Stat. Ann. § 1035.5 (Pennsylvania workers' compensation insurers "shall file with the commissioner

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Order at 5-7 (D. N.J. Sept. 30, 1997). The LHWCA subjects employers to mandatory workers' compensation liability and directs them to secure payment of benefits for injured employers, which they may do by purchasing insurance. 33 U.S.C. §§ 904, 932. LHWCA benefits are a covered employee's exclusive remedy against an employer. *Id.* § 905.

[5] *See, e.g.*, Col. Rev. Stat. §§ 10-4-701 *et seq.*; Conn. Gen. Stat. §§ 38a-363 *et seq.*; Fla. Stat. Ann. §§ 627.730-627.7405; Haw. Rev. Stat. §§ 431:10C-101 *et seq.*; Ky. Rev. Stat. Ann. §§ 304.39-010 *et seq.*; Mass. Ann. Laws ch. 90, § 34M; Mich. Stat. Ann. §§ 24.13101 *et seq.*; Minn. Stat. §§ 65B.41 *et seq.*; N.J. Stat. Ann. § 39:6A-4; N.Y. Ins. Law. §§ 5101 *et seq.*; N.D. Cent. Code §§ 26.1-41-01 *et seq.*; Utah Code Ann. §§ 31A-22-301 *et seq.*

all rates and supplementary rate information"). This Court, however, has never regarded the state's acquiescence in such filings—even where subject to state review—as converting a private party's conduct into state action.

For example, in *Blum*, the Court held that a private nursing home's decision to transfer Medicaid patients could not be attributed to the state despite the fact that "the State requires the nursing homes to complete patient care assessment forms and file them with state Medicaid officials . . . [and] federal law requires that state officials review these assessments." 457 U.S. at 1010 (citations omitted). Similarly, under the analogous "state action" doctrine of the antitrust laws, the conduct of regulated businesses has never been attributed to the state merely because a regulator approves a tariff or similar filing. *See, e.g., Cantor v. Detroit Edison Co.*, 428 U.S. 579 (1976). Yet, under the Third Circuit's test, a regulated company's mere filing with a state regulatory agency and its ministerial, non-substantive review would convert the privately-initiated conduct into state action. The decision below should thus be reviewed because it has the potential for broadly governmentalizing the conduct of private businesses in regulated markets.

II. THE THIRD CIRCUIT'S DUE PROCESS DETERMINATION ALSO MERITS REVIEW

A. The Third Circuit's Ruling Threatens to Eviscerate State Utilization Review and Similar Medical Care Cost Containment Measures

The Third Circuit's due process ruling should also be reviewed because of its significant implications for the cost containment reforms enacted by many states to deal with the workers' compensation financial crisis of the past decade.

Beginning in the mid-1980's, workers' compensation markets in Pennsylvania and many other states entered a long period of turmoil due to exploding costs and insur-

ance rates that did not keep up with the costs. One of the principal causes of this crisis was steeply accelerating medical care costs. From 1985 to 1992, aggregate national medical expenditures for workers' compensation rose from $7.08 billion to $18.25 billion, for an increase of over 157%, compared to a 94% rise in national health care costs overall. S. ECCLESTON & C. YEAGER, WORKERS COMPENSATION RESEARCH INSTITUTE, MANAGED CARE AND MEDICAL COST CONTAINMENT IN WORKERS' COMPENSATION, A NATIONAL INVENTORY, 1997-1998, at 4 (1997).

Overtreatment and fraud, particularly by non-traditional providers such as chiropractors and acupuncturists, was a principal source of the problem. In Pennsylvania, the pre-1993 system created several incentives for providers to overtreat and overbill.

First, the worker, not the employer or insurer paying the bill, had the right to choose the provider following the first fourteen days after an injury. *See* R. VICTOR, J. GARDNER, D. SWEENEY & C. TELLES, WORKERS COMPENSATION RESEARCH INSTITUTE, COST DRIVERS IN SIX STATES, at 94 (1992). Second, "[e]mployers or insurers [were] required to pay disputed medical bills pending resolution of a dispute, with little chance of reimbursement." *Id.* at 94. Third, "[e]ven if a medical bill [was] challenged successfully, reimbursement [came] from a special state fund, not from the provider who submitted the bill. Consequently, providers [had] no incentive to avoid overbilling." *Id.* These problems were compounded because "Pennsylvania employ[ed] few of the cost containment strategies common to other states . . . ." D. BALLANTYNE & C. TELLES, WORKERS COMPENSATION RESEARCH INSTITUTE, WORKERS' COMPENSATION IN PENNSYLVANIA: ADMINISTRATIVE INVENTORY, at xxi (1991).

To address the workers' compensation crisis, in 1993 the Pennsylvania Legislature enacted omnibus reforms, including a provision permitting insurers and self-insured

employers to withhold payment of health care provider bills pending utilization review of the reasonableness or necessity of the treatment. *See* 77 Pa. Stat. Ann. § 531(5); 34 Pa. Code §127.208. In permitting insurers to forebear payment, the Pennsylvania legislation brought the Commonwealth in conformity with the practices in virtually all other states. ECCLESTON & YEAGER, *supra*, at 16, 18-19.

The 1993 reforms in general and the utilization review system in particular have proved remarkably effective. "The most notable system improvement was a sharp drop in medical benefit costs from 1993 to 1995," attributable in large part to the "medical cost controls instituted by the 1993 amendments." D. BALLANTYNE, WORKERS COMPENSATION RESEARCH INSTITUTE, REVISITING WORKERS' COMPENSATION IN PENNSYLVANIA: ADMINISTRATIVE INVENTORY, at xi (1997). From the inception of utilization review until early 1998, there were 41,583 cases decided by utilization review panels. Letter from Timothy Wisecarver, President, Pennsylvania Compensation Rating Bureau, to Mr. Richard Himler, Director, Pennsylvania Bureau of Workers' Compensation (July 1, 1998) (reproduced in the Appendix to this brief). In 43% of those cases, the treatment was found to be unreasonable or unnecessary; in another 24%, the treatment was found to be partly unreasonable or unnecessary. *Id.* Thus, in over two-thirds of all cases, treatment was found to be improper and excessive payments were avoided.

The lower court's decision, however, will render utilization review meaningless as a mechanism to protect against payment for unreasonable and unnecessary treatment. The court struck down that part of the Pennsylvania statute that allowed payments to be delayed beyond thirty days of billing if the insurer requests utilization review. 77 Pa. Stat. Ann. § 531(5). But the utilization review panel, in practice, takes between sixty and ninety days to reach its conclusion. Should it then determine that the treatment

was unnecessary and unreasonable, its decision will have no practical effect. The insurer already will have paid the provider, and the provider is insulated from returning that payment because the insurer is legally barred from recovery. *See Moats v. Workmen's Compensation Appeal Bd.*, 588 A.2d 116, 118 (Pa. Commw. Ct. 1991).

The Third Circuit's ruling will thereby open the door to provider fraud and abuse. Providers will have every incentive to bill for improper treatment because they know they will be able to receive payment but will not be forced to disgorge it even if the treatment is later found unnecessary. The Third Circuit's ruling thus does more than merely impose onerous procedural requirements on utilization review—it frustrates the very purpose of the Pennsylvania reform.

In turn, because the insurer cannot recover fraudulently induced or otherwise excessive payments, the costs of coverage are likely to increase significantly. An illustration of this phenomenon is found in the wake of the three-judge panel's decision in *Baksalary v. Smith*, 579 F. Supp. 218 (E.D. Pa. 1984), *appeal dismissed*, 469 U.S. 1146 (1985). In *Baksalary*, the panel invalidated provisions of a prior Pennsylvania workers' compensation statute that, like the provision in issue here, permitted an employer or insurer unilaterally to suspend disability benefits prior to resolution of a dispute over the worker's continuing eligibility. As in the case of medical benefits, insurers were prohibited from recovering excessive payments from the employee even though subsequently found to be ineligible. Instead, insurers could recover only from a special "supersedeas" fund financed by assessments on them—in essence, requiring the industry to bear the entire cost of the excessive benefits.

In the year that *Baksalary* was decided, reimbursements from the supersedeas fund were fairly minimal, amounting to $1.6 million. *See* BALLANTYNE & TELLES, *supra*, at 37. Since that decision, however, the reimbursements from the fund have skyrocketed to over $25.2 million in

1995, a growth of nearly 1500%. BALLANTYNE, *supra*, at 72. Because the fund reimbursements are "socialized" among insurers and self-insured employers through annual assessments, however, the effect of the *Baksalary* decision has been to greatly increase the insurer's costs of providing coverage.

Insurers are similarly limited to the supersedeas fund in recovering excessive payments to medical care providers. 34 Pa. Code § 127.208(g). The Third Circuit's *Sullivan* ruling thus threatens to greatly increase supersedeas fund assessments on insurers, resulting either in reduced availability of insurance, if the costs must be absorbed by the insurer, or higher rates, if the costs are passed on to employers.

The Third Circuit's ruling also could have significant implications for other lines of insurance, in particular, automobile, disability and health insurance. Many states permit utilization or similar review procedures for medical or disability benefits under these types of policies. Under the Third Circuit's "payment first, review second" approach, the constitutionality of all of these widespread procedures are drawn into question.

B. The Third Circuit's Decision Will Not Protect the Interests of the Injured Employee

The Third Circuit's due process ruling erroneously equated a mere delay in paying the provider's bill with a decision to terminate the employee's medical care benefits. This assumption reflects a basic misunderstanding of the type of utilization review at issue.

The utilization review affecting the plaintiffs in this case was *retrospective* only, that is, a review of a bill for treatment previously given. A delay in paying a bill thus could not affect the availability of treatment *already provided*.

Nor, as a practical matter, does the mere delay in paying for past treatment cause the provider to withhold future treatment. Under Pennsylvania law, if the provider

prevails during the utilization review process, he is entitled to full retroactive relief plus ten percent interest and attorney's fees. 77 Pa. Stat. Ann. §§ 717.1(a), 996(a). The provider also has ethical and legal obligations to continue to provide needed medical care. Not surprisingly, then, several commentators have concluded that retrospective utilization review has little to no effect on an injured employee's access to health care.[6] In short, while purporting to protect the constitutionally-protected interests of the injured worker, the Third Circuit actually is protecting only the provider's interest in getting paid irrespective of the reasonableness of the treatment provided.

Moreover, the Third Circuit's requirement that injured workers be allowed to make written submissions to the utilization review panel giving their subjective or layman's view of treatment is unlikely to improve the accuracy of the panel's determinations. Such decisions, like disability benefits eligibility determinations in cases such as *Mathews v. Eldridge*, 424 U.S. 319 (1976), are made on the basis of objective medical reports. What is "necessary" and "reasonable" medical treatment is determined by established medical protocols and actual medical evaluations. *See* 34 Pa. Code § 127.467 (reviewers must apply "generally accepted treatment protocols" in conducting utilization review). The utilization review panel already has ac-

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[6] *See* A. Fehn, *Comment: Are We Protected from HMO Negligence?: An Examination of Ohio Law, ERISA Preemption, and Legislative Initiatives*, 30 AKRON L. REV. 501, 506 (Summer 1997) ("While these 'retrospective' utilization reviews would sometimes result in an insurer's refusal to pay the health care provider, the review never affected the patient's access to health care.") (footnote omitted); R. Conrad, Jr. & P. Seiter, *Health Plan Liability in the Age of Managed Care*, DEFENSE COUNS. J., April 1995, at 191 (under retrospective utilization review, "[i]ssues of medical necessity and cost effectiveness may be argued between providers and carriers, but the patient's access to care is not directly affected"); P. Mihaly, *Health Care Utilization Review: Potential Exposures to Negligence Liability*, 52 OH. ST. L. J. 1289, 1289 (1991) ("[W]hile a retrospective payment denial may lead to heated disputes over who will pay the doctor or hospital, it usually does not have a significant impact on the patient's care.").

cess to all medical reports relating to the employee and is able to discuss them directly with the provider. *See* 34 Pa. Code § 127.469.

The lower court's misunderstanding of utilization review points to the basic reason why its due process decision should be reviewed. Under the guise of constitutional analysis, the appellate court really made discretionary policy judgments about the proper balance between the employee's interests in obtaining needed medical treatment and the insurer's and employer's interests in preventing fraud and unnecessary treatment. The record demonstrates that the court's judgments were based on serious misconceptions about the workers' compensation system and utilization review. That is why these kinds of judgments should be left in the hands of state legislators and regulators, who are best-equipped to make such judgments.

CONCLUSION

For the reasons stated above, this Court should grant the petition for review of the Third Circuit's decision.

Respectfully submitted,

MARK F. HORNING
Counsel of Record
SHANNEN W. COFFIN
STEPTOE & JOHNSON LLP
1330 Connecticut Avenue, N.W.
Washington, D.C. 20036
(202) 429-8126
Counsel for *Amici Curiae*

APPENDIX

APPENDIX [1]

[PCRB Logo]

Pennsylvania Compensation Rating Bureau
The Widener Building • 6th Floor
One South Penn Square • Philadelphia, PA 19107-3577
(215) 568-2371 • FAX (215) 564-4328

July 1, 1998

VIA FACSIMILE & FIRST CLASS MAIL

Mr. Richard Himler
Director
Bureau of Workers' Compensation
Department of Labor & Industry
Commonwealth of Pennsylvania
1171 South Cameron Street, Room 103
Harrisburg, PA 17104-2501

RE: Utilization Review Experience under Pennsylvania's Workers Compensation Act

Dear Mr. Himler:

Thank you for your office's prompt and cooperative action in providing the Pennsylvania Compensation Rating Bureau (PCRB) with an electronic data file reflecting all utilization review requests filed from the inception of the utilization review processes in Pennsylvaia through the early part of 1998. That information is of great interest and utility to us and will serve as a primary basis for our analysis and review of that process in the context of the recent Sullivan case decision.

The Sullivan case decision would invalidate parts of the utilization review process as previously applied in Pennsylvania, including the invocation of an automatic super-

[1] A copy of this letter was lodged with the Office of the Clerk of the Supreme Court on the date of filing of this brief.

sedeas during the pendency of utilization review requests. To the extent that utilization review requests take longer to decide than the time in which employers or insurers are required to pay medical bills once presented, the loss of the automatic supersedeas provision would require payments which would not be recovered from providers even if the ultimate utilization review decision were to find the treatments not to be reasonable or necessary.

Meaningful evaluation of these possibilities will require additional information, some of which is not currently available, including the ultimate disposition of the Sullivan case through the judicial process and what modifications, if any, are imposed on the workers compensation system at large and the utilization review process in particular in response to that decision. However, I want to take this opportunity to briefly describe what we now know and additional efforts under way to increase our understanding of the utilization review process and the potential ramifications of the Sullivan case thereon.

Using the data file which your office provided, the PCRB has tabulated results of utilization review requests on which at least an initial decision had been rendered. I enclose a copy of that tabulation, which focused on the three most significant "decision indicator" codes contained in the data file as described below:

Decision Indicator: The decision indicator field contains several alphabetic entries, the most common of which are "Y," "N" and "P." A "Y" decision found that the contested medical service(s) *was/were* reasonable and necessary. An "N" decision found that the contested medical service(s) was/were *not* reasonable or necessary. A "P" decision found that the contested medical service(s) was/were reasonable and necessary in *part* and was/were not reasonable or necessary in other *part*. These codes were entered by Bureau of Workers' Compensation staff both for initial decisions and for reconsideration requests processed in Pennsylvania.

In the columnar entries on the left side of the enclosed page we have shown the number of utilization review requests filed, the number of initial decisions rendered by type and numbers of reconsideration decisions rendered by type for each kind of previous initial decision. Thus, the data file contains 48,695 utilization review cases, of which 41,583 had had an initial decision recorded as of the date of production of the Bureau of Workers' Compensation data file. (The remaining 7,112 requests had not yet been decided as of the date of production of the data file we are using.) Some 8,646 cases also had reconsideration decisions recorded as of the date of this data file's production.

We have tracked the combined effects of initial decisions and reconsideration decisions in the matrix shown on the right side of the enclosed page. This matrix shows that "N" decisions were most common, representing somewhat more than 43 percent of all decisions. "Y" decisions were rendered in just over 31 percent of all cases, and "P" decisions resulted in approximately 24 percent of cases.

Since our production of the enclosed tabulation, I have also come to understand that a Decision Indicator "O" began to be used in late 1995. This code indicates a decision that treatment was not reasonable or necessary and that the provider under review did not supply records as requested. While much less common than any other Decision Indicator even after 1995, if added to our tabulation these decisions would serve to increase somewhat the portion of decisions finding that treatment under review was not reasonable or necessary.

The enclosed tabulation clearly demonstrates that the utilization review process as historically applied in Pennsylvania has affected a majority of cases to which the process was applied by finding part or all of disputed treatments not to be reasonable or necessary. At present, the PCRB does not have available information which would quantify the dollar amounts of those effects. However,

we are presently in the process of seeking additional information from many independent sources concerning the dollar values of medical services at issue in utilization review cases, as well as implications of utilization review decisions on ongoing indemnity benefits. As any additional information is obtained in that process, we will continue to keep your office informed.

Sincerely,

/s/ Timothy L. Wisecarver
TIMOTHY L. WISECARVER
President

TLW/kg
Enclosure

Utilization Data Claim Counts

		Reconsideration Results Where Available						
Total Number of claims	48,695							
Total Number with Initial Decision Rendered Date	41,583	**"Y"**	**"N"**	**"P"**	**"Other"**		**Net Count**	
Number with "Y" Initial Decision Indicator	12,100	667	363	295	2	**"Y"**	**13,022**	**31.32%**
Number with "N" Initial Decision Indicator	19,034	1042	3,132	1068	10	**"N"**	**18,016**	**43.33%**
Number with "P" Initial Decision Indicator	9,718	539	737	777	1	**"P"**	**9,807**	**23.58%**
Number with other than above Indicator	731	1	2	3	7	**"Other"**	**738**	**1.77%**
Total Number with Reconsideration Decision Rendered Date	8,646						**41,583**	**100.00%**
Number with "Y" Initial Decision Indicator	1,327							
Number with "Y" Reconsideration Indicator	667							
Number with "N" Reconsideration Indicator	363							
Number with "P" reconsideration Indicator	295							
Number with other than above Indicator	2							
Number with "N" Initial Decision Indicator	5,252							
Number with "Y" Reconsideration Indicator	1,042							
Number with "N" Reconsideration Indicator	3,132							
Number with "P" reconsideration Indicator	1,068							
Number with other than above Indicator	10							
Number with "P" Initial decision Indicator	2,054							
Number with "Y" Reconsideration Indicator	539							
Number with "N" Reconsideration Indicator	737							
Number with "P" reconsideration Indicator	777							
Number with other than above Indicator	1							
Number with other than Y, N, P Init. Dec. Ind.	13							
Number with "Y" Reconsideration Indicator	1							
Number with "N" Reconsideration Indicator	3							
Number with "P" reconsideration Indicator	2							
Number with other than above Indicator	7							

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JUL 10 1998

No. 97-2000

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Supreme Court of the United States
OCTOBER TERM, 1997

AMERICAN MANUFACTURERS MUTUAL INSURANCE COMPANY, *et al.*,
Petitioners,
v.
DELORES SCOTT SULLIVAN, *et al.*,
Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Third Circuit

MOTION FOR LEAVE TO FILE BRIEF *AMICUS CURIAE* AND BRIEF OF THE NATIONAL ASSOCIATION OF WATERFRONT EMPLOYERS, MASTER CONTRACTING STEVEDORE ASSOCIATION OF THE PACIFIC COAST, INC., AND SIGNAL MUTUAL INDEMNITY ASSOCIATION, LTD., AS *AMICI CURIAE* IN SUPPORT OF PETITIONERS

Of Counsel
CARL L. TAYLOR
1015 33rd Street, NW
Suite 811
Washington, DC 20007
(202) 338-6644

CHARLES T. CARROLL, JR.*
F. EDWIN FROELICH
WILCOX, CARROLL & FROELICH, P.L.L.C.
2011 Pennsylvania Avenue, NW
Suite 301
Washington, DC 20006
(202) 296-3005

* Counsel of Record

WILSON - EPES PRINTING CO., INC. - 789-0096 - WASHINGTON, D.C. 20001

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MOTION FOR LEAVE TO FILE BRIEF *AMICUS CURIAE*

Pursuant to Rule 37 of the Supreme Court of the United States, the National Association of Waterfront Employers (NAWE), the Master Contracting Stevedore Association of the Pacific Coast (MCSA), and Signal Mutual Indemnity Association, Ltd., move for leave to file this brief *amicus curiae* in support of Petitioners.[1]

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[1] Written consent has been obtained from Counsel for the Petitioners and filed with the Clerk of the Court. Counsel for Respondents has not so consented. Pursuant to Rule 37.6, counsel of record states that no part of this brief has been authored by counsel for either party or any other entity. Rather, it has been authored in its entirety by named counsel. No monetary contribution for the preparation of this brief was solicited or received from any party to the Petition. This brief was funded solely by the *amici*.

The first question presented in the petition for a writ of certiorari presents an important question of law, with ramifications well beyond the proper reach of the Fourteenth Amendment's Due Process Clause. The Circuit Court's broad state action/due process analysis is certain to influence state action jurisprudence as it may be applied to similar Fifth Amendment challenges to employer decisions to suspend benefit payments made under federal law. As this Court noted in *Mathews v. Eldridge*, 424 U.S. 319, 332 (1976), due process analysis is the same within the meaning of the Due Process Clause of the Fifth or Fourteenth Amendment.[2]

Any possible extension of the Circuit Court of Appeal's state action rationale to Fifth Amendment due process jurisprudence is of vital concern to *amici*. This concern is not academic. *Amici* call to the Court's attention the fact that the Circuit Court will shortly be in a position to extend its state action/due process rationale to questions arising under a *federal* statutory benefit scheme. Litigation is now pending within the circuit that presents a due process challenge based on the Fifth Amendment to the benefit scheme set forth in the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. § 901 *et seq.* (LHWCA).[3]

[2] State action analysis is also the same under the Fifth and Fourteenth Amendments. See *Edmonson v. Leesville Concrete Co.*, 500 U.S. 614 (1991), a state action case arising under the Fifth Amendment and using Fourteenth Amendment analysis.

[3] See *Kreschollek v. Southern Stevedoring*, Civil No. 93-3903 (JHR) (D.N.J., Sept. 30, 1997). This litigation has a lengthy history. After the claimant informed the employer of the injury, the employer/insurance carrier initiated voluntary payments. Subsequently, after receiving further medical evidence, the insurance carrier suspended payments. Kreschollek then filed a claim with the Department of Labor, which the insurance carrier controverted under the LHWCA. The claimant also filed a separate Fifth Amendment due process facial challenge to the LHWCA's suspension provisions in federal District Court seeking a pre-deprivation hearing. The District Court has issued one decision on the state action aspect of the constitutional claim. See *id.* The Third Circuit Court of Appeals has also issued a decision on subject matter jurisdiction. *Kreschollek v. Southern Stevedoring*, 78 F.3d 868 (1996). Meanwhile, the ALJ assigned to adjudicate Kreschollek's underlying LHWCA claim rendered a decision finding it to be without merit, a decision upheld by the Benefits Review Board and ultimately by the Third Circuit. *Kreschollek v. Southern Stevedoring*, 129 F.3d 1255 (1997).

Despite the fact that the LHWCA permits private self-insured employers/insurance carriers to suspend—without a hearing—the payment of indemnity benefits initially paid to a claimant on a *voluntary* basis, one District Court has issued an order finding that, under the LHWCA's indemnity compensation scheme, insurance carriers (and, by implication, self-insured employers) are state/government actors for purposes of a Fifth Amendment based due process inquiry. The District Court's rationale parallels the rationale of the decision below, and both rely on many common authorities. The District Court has now scheduled a trial to determine whether or not the Due Process Clause requires a hearing before an employer may suspend these voluntary benefits.

Amici submit that the answer to the first question presented in the petition for review will have a direct effect on the 27,000+ decisions made each year by self-insured employers and/or insurance carriers subject to the LHWCA to either pay compensation benefits to claimants on a voluntary basis in the first instance, or to controvert benefit claims and delay payment until a formal award is made by the adjudicative arm of the Department of Labor. The self-insured employer-members of NAWE and the MCSA, along with all of the members of Signal Mutual Indemnity Association, Ltd., together comprise a substantial portion of the employers subject to the jurisdiction of the LHWCA and will be faced with making many of these financialy burdensome decisions.[4]

[4] The National Association of Waterfront Employers (NAWE), is a not-for-profit tax exempt [26 U.S.C. § 501(c)(6)] trade association organized under the laws of the District of Columbia whose

Should the members of *amici* be confronted by this untenable choice, they are certain to be harmed. Instead of being faced with a statutory scheme encouraging the payment of voluntary benefit compensation, without the need for litigation, *amici* routinely will be placed in a position of either expending financial resources—even when undeserved and with no real prospect of recovering payments—until the Department of Labor can hear the case and render a decision, or suspending payment (and risking a penalty for non-payment) of benefits while forcing many claimants to forego a stream of benefits to which he or she may be temporarily entitled.

Amici submit that only review of the decision below can correct the Court of Appeals' misguided expansion of the state action doctrine, and prevent its likely application to future Due Process Clause challenges to employer benefit decisions taken under *federal* benefit laws. Accordingly, *amici* respectfully move for leave to file the attached brief *amicus curiae* in support of Petitioners' request for a writ of certiorari.

Respectfully submitted,

Of Counsel

CARL L. TAYLOR
1015 33rd Street, NW
Suite 811
Washington, DC 20007
(202) 338-6644

CHARLES T. CARROLL, JR.*
F. EDWIN FROELICH
WILCOX, CARROLL & FROELICH, P.L.L.C.
2011 Pennsylvania Avenue, NW
Suite 301
Washington, DC 20006
(202) 296-3005

* Counsel of Record

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35 member companies are private sector stevedores/marine terminal operators doing business throughout the U.S. With the exception of the Puerto Rico members, every NAWE member company employs longshore labor engaged in maritime employment subject to the Longshore and Harbor Workers' Compensation Act.

The Master Contracting Stevedore Association of the Pacific Coast, Inc. (MCSA) is a not-for-profit trade association whose 15 member private sector companies provide contract stevedoring services in all principal ports in the states of California, Oregon and Washington, and provide substantially all the maritime terminal and stevedoring services performed by private contractors to oceangoing vessels calling at ports in these states.

Signal Mutual Indemnity Association, Ltd. is the largest self-insurance facility authorized by the Secretary of Labor to secure the benefits payable under the LHWCA on a non-profit and cost effective basis for selected employers over the long term.

QUESTIONS PRESENTED

1. Whether this Court should replace *Burton v. Wilmington Parking Authority*, 365 U.S. 715 (1961), with a "uniform and predictable standard" * for determining when a private party is subject to constitutional restraints as a state actor.

2. Whether a private party should be subject to constitutional restraints as a state actor only when the state has affirmatively influenced or coerced the private party's action (a "direction case") or participated in the private party's action (a "participation case").

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* *Burlington Industries, Inc. v. Ellerth*, —— U.S. ——, —— (June 26, 1998).

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STATEMENT OF INTEREST OF THE *AMICI CURIAE*

The interest of *amici curiae* in this matter is detailed in the accompanying Motion for Leave to File Brief *Amicus Curiae* in Support of Petitioners and, in the interest of reducing the burden on the Court, will not be restated but is to be incorporated herein.

STATEMENT OF CASE

The petitioners in the present case are private insurance companies that provide workers' compensation insurance to employers in Pennsylvania and elsewhere. The respondents are ten employees and two employee organizations who claim that the petitioners violated the due process requirements of the Fourteenth Amendment when they decided to suspend payment for individual medical treatments pending independent utilization review of the reasonableness of the treatments. Petitioners' Appendix "Pet. App." at 9a.

The Pennsylvania workers' compensation statute contains a procedure for reviewing the reasonableness of a particular medical treatment. The procedure begins with a utilization review and report by an independent health care provider. Either the employee or the insurer may then obtain a de novo hearing before an administrative law judge. Pet. App. at 4a-9a.

This procedure is invoked by the insurer, who files a form with the State. The filing is *pro forma*. If it contains all the necessary information, the State authorizes the initiation of the review process. Pet. App. at 5a.

At this point, the insurer "may suspend payment for the medical treatment in question. [Citation omitted.] The Act does not require—but permits—suspension of medical benefits." Pet. App. at 5a. If the independent health care provider reports that the treatment is reasonable, the suspension must be lifted. Otherwise, it may continue until the administrative law judge makes a decision. Pet. App. at 9a.

The District Court dismissed the employees' complaint against the insurance companies on the ground that the companies' action was not state action under the Fourteenth Amendment. The District Court said (Pet. App. at 59a):

> [T]he decision to cease paying medical benefits is entirely up to the insurer acting independent of any state involvement whatsoever. The state takes no substantive step to promote, support or encourage the decision of the insurer; and after the decision is made, the state takes no action which influences the ultimate substantive determination as to whether benefits are payable or not. The state does not signficantly assist private actors when it merely provides a remedy, albeit complete with authorized forms and regulations. The state's acceptance and routing of forms * * * involves acquiescence and not compulsion on the part of the state.

The Court of Appeals reversed. On the same facts as those recited by the District Court, the Court of Appeals held (Pet. App. at 14a-15a):

> Although the insurance companies are private entities, when they act under the construct of the Workers' Compensation System, they are providing public benefits which honor State entitlements. In effect, they become an arm of the State, fulfilling a uniquely governmental obligation under an entirely state-created, self-contained public benefit system.

SUMMARY OF ARGUMENT

The decision of the Circuit Court ignores several controlling opinions of this Court, especially *Blum v. Yaretsky*, 457 U.S. 991 (1982), issued as part of the 1982 trilogy of opinons that attempted to provide a degree of predictability to the admittedly difficult questions surrounding state action/due process jurisprudence. As such, review of the decision below should be viewed as an opportunity to replace the source of this difficulty, the unconstrained-by-precedent view of state action outlined in *Burton v. Wilmington Parking Authority*, 365 U.S. 715 (1961), with a more suitable test providing for greater predictability.

Amici submit that *Burton's* approach should now be rejected in favor of a more predictable test drawn from several recent precedents of the Court. Specifically, *amici* suggest that the actions of a private actor should only be held actionable under the state action/due process doctrine if the state has affirmatively influenced or coerced the private actor (a "direction case") or has participated in the private party's action (a "participation case").

Amici submit that failure to provide a predictable state action/due process test will result in numerous Due Process Clause challenges to other employer benefit decisions governed by *federal* benefit statutes.

ARGUMENT

I. THE WRIT SHOULD BE GRANTED IN THE INTEREST OF RESOLVING THIS COURT'S "DIFFICULT" STATE ACTION JURISPRUDENCE.

Amici submit that *Blum v. Yaretsky ("Blum")*, 457 U.S. 991 (1982) should have controlled the present case. There, state action was alleged in the "discharge or transfer of [Medicaid] patients to lower levels of care without adequate notice or hearings," * * * and "[t]he decisions about which respondents complain [were] made by physicians and nursing home administrators, all of whom are concededly private parties." *Id.* at 1005. This Court declined to hold that the private conduct in question was "the exclusive prerogative of the State," *id.* at 1011, refused to hold that "the State, by requiring completion of a form, is responsible for the physician's decision," *id.* at 1006-1007, and "conclude[d] that respondents have failed to establish 'state action' in nursing homes' decisions to discharge or transfer Medicaid patients to lower levels of care." *Id.* at 1012.

The Court of Appeals here distinguished *Blum* as not involving "a comprehensive statutory scheme similar to that present in this case." Pet. App. at 18a. But *Blum* involved Medicaid, a statutory scheme at least as comprehensive as workers' compensation. Also distinguished as not involving "a comprehensive statutory scheme" were *Rendell-Baker v. Kohn ("Rendell-Baker")*, 457 U.S. 830 (1982) (finding no state action when a private school fired employees despite the fact that the school was financed almost exclusively from public sources and was extensively regulated by government); *Flagg Brothers v. Brooks ("Flagg Brothers")*, 436 U.S. 149 (1978) (finding no state action when a private warehouseman invoked the self-help provisions of New York's Uniform Commercial Code by selling goods entrusted to him); and *Jackson v. Metropolitan Edison Co. ("Jackson")*, 419 U.S. 345 (1974) (finding no state action when a privately owned electric utility terminated a customer's electric service for nonpayment without a hearing). Pet. App. at 18a. In emphasizing the "comprehensive statutory scheme" as a code phrase for state regulation, the Court of Appeals here ignored *Blum's* admonition that "'[the] mere fact that a business is subject to state regulation does not by itself convert its action into that of the State for purposes of the Fourteenth Amendment.'" 457 U.S. at 1004 (quoting from *Jackson*, 419 U.S. at 350).

The Court of Appeals emphasized the difficulty of finding a guiding legal principle in an area where "[v]arious cases have led to differing results in factual scenarios that, at least upon first impression, appear to be similar." Pet. App. at 13a. It then said (Pet. App. at 13a):

> To compound the confusion surrounding a state action examination, courts have employed various tests and standards that have been anything but a model of clarity.

The Court of Appeals concluded that it should base its decision upon "the unique context" of the facts before it. Pet. App. at 19a. In doing so, it accepted the authorization of *Burton v. Wilmington Parking Authority ("Bur-*

ton"), 365 U.S. 715 (1961), to treat each state action case as factually unique and, therefore, unconstrained by precedent.

Burton held that defining state action by private parties is an "impossible task." 365 U.S. at 722. It decided that "[o]nly by sifting facts and weighing circumstances can the nonobvious involvement of the State in private conduct be attributed its true significance." *Id. Burton* concluded that "readily applicable formulae may not be fashioned," so that each case "can be determined only in the framework of the peculiar facts or circumstances present." *Id.* at 725-726.[1] Justice Harlan, in dissent, characterized the *Burton* approach as "indiscriminately throwing together various factual bits and pieces." *Id.* at 728.

For the last thirty-seven years *Burton* has framed this Court's state action debate, with majority and dissenting opinions applying and distinguishing *Burton.* So much has *Burton* been at the center of the debate that Justices Brennan and Marshall, dissenting in *San Francisco Arts & Athletics, Inc. v. United States Olympic Comm. ("USOC"),* 483 U.S. 522 (1987), felt entitled to complain that Justice Powell's majority opinion in that case "fails to mention *Burton v. Wilmington Parking Authority,*" despite the fact that "[i]n each of the decisions principally relied on today [by the majority], the Court thought it important to discuss and distinguish *Burton.*" *USOC* at 556 n.12.

The result of this debate, according to the appellate court here, has been "one of the most troublesome issues of constitutional law." Pet. App. at 13a. This Court has acknowledged the problem as well, describing state action decisions as "difficult terrain," *Lebron v. National Rail-*

[1] The *Oxford English Dictionary* (CD-ROM ed., ver. 1.02, 1992) defines "peculiar" as "sui generis" (Definition 4a), which corresponds to the "unique context" approach of the Court of Appeals in the present case.

road Passenger Corp., 513 U.S. 374, 378 (1995), and as "not a model of consistency," *id.*, quoting from *Edmondson v. Leesville Concrete Co.,* 500 U.S. 614, 632 (1991) (O'Connor, J., dissenting). Indeed, this Court alluded to the problem in 1982, when it said:

> [T]he Court has articulated a number of different factors or tests in different contexts * * * Whether these different tests are actually different in operation or simply different ways of characteriziig the necessarily fact-bound inquiry that confronts the Court in such a situation need not be resolved here. See *Burton, supra,* at 722 * * *

Lugar v. Edmondson Oil Co. ("Lugar"), 457 U.S. 922, 939 (1982).

The problem inherent in the "fact-bound" *Burton* inquiry is that no decision is ever controlling on future cases unless the facts are exactly the same. What *Burton* really holds is that each succeeding court is free to assess the equities anew, as the Court of Appeals has done here in finding *Blum* not to be controlling because workers' compensation regulation is different from Medicaid regulation. As long as the *Burton* approach is alive, each state action decision of this Court is subject to being "treated like a restricted railroad ticket, 'good for this day and train only.'" *County of Washington, Oregon v. Gunther,* 452 U.S. 161, 183 (1981) (Rehnquist, J., dissenting), quoting from *Smith v. Allwright,* 321 U.S. 649, 669 (1944) (Roberts, J., dissenting).

Amici submit that the petition for a writ of certiorari should be granted in the interest of resolving the Court's "difficult" state action/due process jurisprudence. It is time to replace *Burton* with "a uniform and predictable standard." *Burlington Industries, Inc. v. Ellerth, supra,* —— U.S. at —— (June 26, 1998).

II. BURTON'S "UNIQUE CONTEXT" STANDARD CAN BE REPLACED WITH A MORE PREDICTABLE STANDARD, CENTERED ON GOVERNMENT INFLUENCE OR PARTICIPATION.

In 1982 this Court stated the objective of modern state action jurisprudence as follows:

> Careful adherence to the "state action" requirement preserves an area of individual freedom by limiting the reach of federal law and federal judicial power. It also avoids imposing on the State, its agencies or officials, responsibility for conduct for which they cannot fairly be blamed. A major consequence is to require the courts to respect the limits of their own power as directed against state governments and private interests. Whether this is good or bad policy, it is a fundamental fact of our political order.

Lugar, supra, 457 U.S. at 936-937. This statement is incompatible with *Burton's* search for "the nonobvious involvement of the State in private conduct," 365 U.S. at 722, and with *Burton's* offspring, the "symbiotic relationship" test. See *Rendell-Baker, supra*, 457 U.S. at 847 (Marshall, J., dissenting).

This *Lugar* statement contemplates clear and usable boundaries around the state action concept. *Jackson, Flagg Bros., Blum, and Rendell-Baker* are examples of such boundaries.

> These cases differ markedly from the "interdependence" or "joint participation" analysis of Burton and stand for the principle that, unless the Government affirmatively influenced or coerced the private party to undertake the challenged action, such conduct is not state action for constitutional purposes.

Lebron, supra, 513 U.S. at 411 (O'Connor, J., dissenting). The principle just stated informs what *amici* have called the "direction case," in which a private party becomes a state actor if the state has affirmatively influenced or coerced the private party's action. What *amici* have called the "participation case" is illustrated by *Lugar* itself, in which a private party induced the state wrongfully to attach another's property. "[P]rivate use of the challenged state procedures with the help of state officials constitutes state action for purposes of the Fourteenth Amendment." *Lugar, supra*, 457 U.S. at 933. Other "participation cases" are *Edmonson v. Leesville Concrete Co. ("Leesville Concrete")*, 500 U.S. 614 (1991), and *Shelley v. Kraemer*, 334 U.S. 1 (1948), in which private parties used court procedures to accomplish unconstitutional objectives:

> In [*Leesville Concrete*], the Court held that a private attorney's exercise of a peremptory challenge is attributable to the government and therefore subject to constitutional inquiry. Although the opinion cited *Burton, see* 500 U.S. at 621, 624, it emphasized that a private party exercising a peremptory challenge enjoys the 'overt, significant assistance of the court,' *id.*, at 624. The decision therefore is an application of *Shelley v. Kraemer*, 334 U.S. 1, 19 (1948), which focused on the use of the State's coercive power, through its courts, to effect the litigant's allegedly unconstitutional choice.

Lebron, supra, 513 U.S. at 411 (O'Connor, J., dissenting).

"Given the pervasive role of government in our society, a test of state action predicated upon public and private 'interdependence' sweeps much too broadly and would subject to constitutional challenge the most pedestrian of everyday activities. . . ." *Id.* "A more refined inquiry" (*id.*) is needed. *Amici* submit for the Court's consideration the direction and participation standards framed in our statement of the second question, presented above.[2]

---

[2] Cases such as *West v. Atkins*, 487 U.S. 42 (1988) (state action found where the state delegates a nondelegable duty to a private actor), and *Polk County v. Dodson*, 454 U.S. 312 (1981) (state action not found in representation of a criminal defendant by a public defender paid from state funds because state supervision of the representation would be a conflict of interest) are special situations involving the role of government and are not included here.

CONCLUSION

The present case is an appropriate vehicle for reconsideration and replacement of the *Burton* standard. The reliance interest in *Burton* is minimal, because *Burton* articulated no predictable rule of law. Indeed, consistency is the greatest reliance objective, and *Burton* stands in the way. See *Hohn v. United States*, —— U.S. —— (June 15, 1998), overruling *House v. Mayo*, 324 U.S. 42 (1945) ("Once we have decided to reconsider a particular rule, however, we would be remiss if we did not consider the consistency with which it has been applied in practice. [Citations omitted.] This consideration, when combined with our analysis of the legal issue in question, convinces us the contrary holding of House v. Mayo cannot stand.")

The petition for a writ of certiorari should be granted.

Respectfully submitted,

Of Counsel

CARL L. TAYLOR
1015 33rd Street, NW
Suite 811
Washington, DC 20007
(202) 338-6644

CHARLES T. CARROLL, JR.*
F. EDWIN FROELICH
WILCOX, CARROLL & FROELICH,
P.L.L.C.
2011 Pennsylvania Avenue, NW
Suite 301
Washington, DC 20006
(202) 296-3005

* Counsel of Record

No. 97-2000

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In the Supreme Court of the United States

OCTOBER TERM, 1997

AMERICAN MANUFACTURERS MUTUAL INSURANCE COMPANY, ET AL., PETITIONERS

v.

DELORES SCOTT SULLIVAN, ET AL., RESPONDENTS

On Writ of Certiorari to the United States Court of Appeals for the Third Circuit

JOINT APPENDIX

MICHAEL W. MCCONNELL
Counsel of Record
ALAN E. UNTEREINER
STEFFEN N. JOHNSON
SHARON SWINGLE
Mayer, Brown & Platt
190 South LaSalle Street
Chicago, IL 60603
(312) 782-0600

Counsel for All Petitioners

ROBERT MCL. BOOTE
BURT M. RUBLIN
Ballard Spahr Andrews & Ingersoll, LLP
1735 Market Street
Philadelphia, PA 19103
(215) 665-8500

Counsel for All Petitioners Except Donegal Mut. Ins. Co.

LORALYN MCKINLEY
Counsel of Record
McKinley and Vonier
1333 Race Street
Philadelphia, PA 19107
(215) 569-1644

Counsel for Delores Scott Sullivan, William Battle, Anthony Cancila, Louis Baumgartner, and Class Plaintiffs

ALAN B. EPSTEIN
Jablon Epstein
The Bellevue, Ninth Fl.
Broad Street at Walnut
Philadelphia, PA 19102
(215) 790-0300

Counsel for Charles Matthews, Christopher Costello, Lisa Lex, Susan Hansen, Terrence Ervine, William C. Dillon, and Class Plaintiffs

(Additional Counsel Listed on Inside Cover)

PETITION FOR CERTIORARI FILED JUNE 11, 1998
CERTIORARI GRANTED SEPTEMBER 29, 1998

59 pp

ROBERT E. KELLY, JR.
Duane, Morris, Hecksher LLP
305 N. Front Street
Harrisburg, PA 17108
(717) 237-5500

Counsel for Donegal Mut. Ins. Co.

THOMAS J. O'BRIEN
Galfand, Berger, Lurie, Brigham Jacobs, Swan, Jurewicz, & Jensen
1818 Market Street
23rd Floor
Philadelphia, PA 19103
(215) 665-6814

Counsel for PhilaPOSH

LINDA M. MARTIN
Willig, Williams & Davidson
1845 Walnut Street, 24th Floor
Philadelphia, PA 19103
(215) 656-3600

Counsel for Intervenor Philadelphia Federation of Teachers

D. MICHAEL FISHER
SUSAN J. FORNEY
JOHN G. KNORR, III
Counsel of Record
Office of Attorney General
15th Floor, Strawberry Sq.
Harrisburg, PA 17120
(717) 783-1471

Counsel for Pennsylvania Secretary of Labor and Industry, Director of the Pennsylvania Bureau of Workers' Compensation, Pennsylvania Insurance Commissioner, Pennsylvania Treasurer, and Director of the State Workers' Insurance Fund

JAN M. RITCHIE
Counsel of Record
JAMES M. TYLER
PATRICIA FARRELL KERELO
Schubert, Bellwoar, Cahill & Quinn
1500 John F. Kennedy Blvd.
Suite 1400
Philadelphia, PA 19102
(215) 587-0146

Counsel for the School District of Philadelphia

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RELEVANT DOCKET ENTRIES NOT INCLUDED

The following opinions, decisions, judgments, and orders have been omitted in printing this joint appendix because they appear at the pages indicated in the appendix to the Petition for a Writ of Certiorari:

Memorandum Opinion and Order of the United States District Court for the Eastern District of Pennsylvania, dated January 24, 1996 . . . . . 41a

Memorandum Opinion and Order of the United States District Court for the Eastern District of Pennsylvania, dated November 7, 1996 . . . . . 62a

Order of the United States District Court for the Eastern District of Pennsylvania, dated December 13, 1996 . . . . . 82a

Decision and Judgment of the United States Court of Appeals for the Third Circuit, dated March 13, 1998 . . . . . 1a

RELEVANT DOCKET ENTRIES

January 12, 1995	Complaint filed.
April 10, 1995	Motion to dismiss complaint filed by American Manufacturers Mutual Insurance Company, Continental Casualty Company, USF&G Insurance Company, and Zurich American Insurance Company.
April 10, 1995	Motion to dismiss complaint filed by School District of Philadelphia.
July 28, 1995	Motion for partial summary judgment filed by plaintiffs.
January 24, 1996	Memorandum and order granting motion to dismiss filed by American Manufacturers Mutual Insurance Company, Insurance Company of North America, Continental Casualty Company, USF&G Insurance Company, and Zurich American Insurance Company, denying motion to dismiss filed by School District of Philadelphia, and denying plaintiffs' motion for partial summary judgment filed.
May 16, 1996	Motion for leave to amend complaint filed by plaintiffs.
May 21, 1996	Order granting plaintiffs' motion for leave to amend complaint and dismissing insurer defendants filed.
May 21, 1996	Amended complaint filed.

June 20, 1996	Motion to dismiss filed by Catherine Baker Knoll, Johnny J. Butler, Richard A. Himler, Linda Kaiser, and Ralph Chase (collectively, the "Commonwealth Officials").
November 7, 1996	Order granting Commonwealth Officials' motion to dismiss filed.
December 6, 1996	Motion for judgment filed by School District of Philadelphia.
December 13, 1996	Order granting School District of Philadelphia's motion for judgment filed.
March 13, 1998	Opinion and judgment by the U.S. Court of Appeals for the Third Circuit reversing and remanding to the district court for further proceedings entered.
September 29, 1998	Order of the Supreme Court of the United States granting certiorari filed.

IN THE UNITED STATES DISTRICT COURT FOR
THE EASTERN DISTRICT OF PENNSYLVANIA

CIVIL ACTION NO. 95-CV-201

DELORES SCOTT SULLIVAN, WILLIAM BATTLE,
ANTHONY CANCILA, CHARLES MATTHEWS,
CHRISTOPHER COSTELLO, LISA LEX,
AND SUSAN HANSEN
On Their Own Behalf and on Behalf of
All Similarly Situated Class Plaintiffs

and

PHILADELPHIA AREA PROJECT ON
OCCUPATIONAL SAFETY AND HEALTH

v.

ROBERT BARNETT, Secretary of Labor and
Industry for the Commonwealth of
Pennsylvania;

and

FRANK BEAL, Director of the Pennsylvania
Bureau of Workers Compensation

and

CONSTANCE B. FOSTER, Insurance Commissioner
For the Commonwealth of Pennsylvania;

and

CATHERINE BAKER KNOLL, Treasurer,
Commonwealth of Pennsylvania;

and

JOHN P. O'MALLEY, Director,
State Workers' Insurance Fund;

and

AMERICAN MANUFACTURERS MUTUAL INSURANCE COMPANY;

and

CIGNA CORPORATION;

and

CONTINENTAL CASUALTY COMPANY;

and

USF&G INSURANCE COMPANY;

and

ZURICH AMERICAN INSURANCE COMPANY;

and

SCHOOL DISTRICT OF PHILADELPHIA

INSURER DEFENDANTS' MOTION TO DISMISS COMPLAINT

[TEXT OF MOTION OMITTED IN PRINTING]

EXHIBIT A

EDITOR'S NOTE

THE FOLLOWING PAGES WERE POOR HARD COPY AT THE TIME OF FILMING. IF AND WHEN A BETTER COPY CAN BE OBTAINED, A NEW FICHE WILL BE ISSUED.

UTILIZATION REVIEW: INITIAL REQUEST

This Request filed by or on behalf of: ☐ Employee or ☐ Employer/Insurer

EMPLOYEE NAME

STREET ADDRESS

COUNTY CITY TOWN | STATE | ZIP CODE

EMPLOYER

STREET ADDRESS

CITY/TOWN | STATE | ZIP CODE

PROVIDER NAME

PROFESSIONAL DEGREE OR TITLE

STREET ADDRESS

CITY/TOWN | STATE | ZIP CODE

☐☐☐ - ☐☐ - ☐☐☐☐
SOCIAL SECURITY NUMBER

☐☐ - ☐☐ - ☐☐
DATE OF INJURY

INSURANCE CARRIER
(or adjusting company if self-insured)

STREET ADDRESS

CITY/TOWN | STATE | ZIP CODE

PROVIDER'S SPECIALTY/PRACTICE

TREATMENT/PROCEDURE TO BE REVIEWED

DATE(S) OF TREATMENT/PROCEDURE TO BE REVIEWED

TO THE BUREAU:

I hereby request that the Bureau of Workers' Compensation assign an authorized utilization review organization to review the reasonableness and necessity of proposed, current or past care of the above employee, for the following reason(s): (Please be as specific as possible.)

I hereby certify that a copy of this request has been served on all parties concerned on _____ (DATE) at the address shown above.

SIGNATURE OF REQUESTING PARTY OR REPRESENTATIVE

STREET ADDRESS

CITY/TOWN | STATE | ZIP CODE

( ) TELEPHONE NUMBER

[LOGO OMITTED IN PRINTING]

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF LABOR AND INDUSTRY
BUREAU OF WORKERS' COMPENSATION
1171 SOUTH CAMERON STREET; ROOM 103
HARRISBURG, PENNSYLVANIA 17104-2501
(717) 772-1914

NOTICE OF ASSIGNMENT OF UTILIZATION REVIEW: INITIAL REQUEST

NOTICE TO THE URO: You have five (5) business days from receipt of this Notice to make a written request for all necessary records and other relevant information from the provider under review. You must complete your review and render your report within thirty (30) calendar days of the date you receive the records and information or within sixty-five (65) calendar days of the date of this notice, whichever is earlier. If you have not received the records and information within thirty (30) calendar days of the request you may proceed with your review.

You have been assigned this case to render a determination only as to the reasonableness or necessity of the care under review. You may not give an opinion as to causation of the underlying injury or disease or the extent of the employee's disability under the Workers' Compensation Act. Also, do not render an opinion as to the reasonableness of a fee.

You must return this request to the Bureau for reassignment if you do not have the expertise or ability to render the review sought, or if you have a conflict with rendering this review. You must disqualify yourself from this review on the basis of a conflict if you have previously rendered an opinion on

this treatment for another purpose, including case management, review on behalf of a CCO or pre-review screening on behalf of an employer/insurer.

NOTICE TO EMPLOYER/INSURER: You must pay the reasonable and customary charge of the URO for its services upon initial review. Payment must be timely.

NOTICE TO HEALTH CARE PROVIDER: You must provide all necessary records and other relevant information to the URO within thirty (30) calendar days of the date of its request. If you fail to do so, the URO may proceed with its review, resulting in a determination against your interest.

[REMAINING EXHIBITS OMITTED IN PRINTING]

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

CIVIL ACTION NO. 95-CV-201

DELORES SCOTT SULLIVAN, WILLIAM BATTLE, LOUIS BAUMGARTNER, ANTHONY CANCILA, WILLIAM C. DILLON, By His Guardian and Next Friend, PAULINE DILLON, TERRENCE ERVINE, CHARLES MATTHEWS, CHRISTOPHER COSTELLO, LISA LEX, AND SUSAN HANSEN
On Their Own Behalf and on Behalf of All Similarly Situated Class Plaintiffs

and

PHILADELPHIA AREA PROJECT ON OCCUPATIONAL SAFETY AND HEALTH

and

PHILADELPHIA FEDERATION OF TEACHERS,
Intervenors

v.

JOHNNY J. BUTLER, Secretary of Labor and Industry for the Commonwealth of Pennsylvania;

and

RICHARD A. HIMLER, Director of the Pennsylvania Bureau of Workers Compensation

and

CONSTANCE B. FOSTER, Insurance Commissioner For the Commonwealth of Pennsylvania;

and

CATHERINE BAKER KNOLL, Treasurer,
Commonwealth of Pennsylvania;

and

JOHN P. O'MALLEY, Director,
State Workers' Insurance Fund;

and

AMERICAN MANUFACTURERS MUTUAL
INSURANCE COMPANY;

and

CIGNA CORPORATION;

and

COMMERCIAL UNION INSURANCE COMPANY;

and

CONTINENTAL CASUALTY COMPANY;

and

DONEGAL MUTUAL INSURANCE COMPANY;

and

HARTFORD INSURANCE COMPANY;

and

USF&G INSURANCE COMPANY;

and

ZURICH AMERICAN INSURANCE COMPANY;

and

SCHOOL DISTRICT OF PHILADELPHIA

AMENDED COMPLAINT-CLASS ACTION

I. PRELIMINARY STATEMENT

1. This is a civil rights action brought by named and class plaintiffs who had been receiving medical benefits pursuant to the Pennsylvania Worker's Compensation Act, 77 P.S. § 1, et seq., and who have been deprived of those benefits without prior notice and opportunity to be heard pursuant to the utilization review procedures contained in Sections 306(f.1)(5) and (6) of the Pennsylvania Workers' Compensation Act, as amended, 77 P.S. § 531(5) and (6) (Supp. 1994). Plaintiffs contend that Section 306(f.1)(5) and (6), which were passed by the Pennsylvania General Assembly in July, 1993 as part of a larger cost containment measure known as "Act 44", violate the Due Process Clause of the Fourteenth Amendment and 42 U.S.C. § 1983. Plaintiffs seek to have Section 306(f.1)(5) and (6) declared unconstitutional and further, to enjoin the named and class defendants from enforcing, acting or relying upon these provisions to withhold workers compensation medical benefits from the named and class plaintiffs. Plaintiffs additionally seek restoration of all benefits which have been withheld as a result of the unconstitutional utilization review procedures, as well as compensatory and punitive damages.

II. JURISDICTION

2. This is an action arising under 42 U.S.C. § 1983 seeking to redress the deprivation under color of state law of rights secured to the named and class plaintiffs by the United States Constitution. Jurisdiction is therefore predicated upon 28 U.S.C. § 1343(3) and (4). Jurisdiction is also conferred upon this Court by 28 U.S.C. §1331, since this case presents a federal question.

3. Declaratory and injunctive relief is sought pursuant to 28 U.S.C. §§ 2201-2202.

4. The named and class plaintiffs have no adequate remedy at law and have suffered, and will suffer, immediate and irreparable harm from the state action complained of herein, unless equitable relief is granted to them.

III. PARTIES

Plaintiffs-Individual

5. DELORES SCOTT SULLIVAN is a citizen of the United States and the Commonwealth of Pennsylvania who resides at 3230 N. Dover Street, Philadelphia, PA 19129.

6. WILLIAM BATTLE is a citizen of the United States and the Commonwealth of Pennsylvania who resides at 8552 Marsden Street, Philadelphia, PA 19136.

7. LOUIS BAUMGARTNER is a citizen of the United States and the Commonwealth of Pennsylvania who resides at 717 Mercer Street, New Castle, PA 16101.

8. ANTHONY CANCILA is a citizen of the United States and the Commonwealth of Pennsylvania who resides at 2151 Disston Street, Philadelphia, PA 19149.

9. CHRISTOPHER COSTELLO is a citizen of the United States and the State of New Jersey who resides at 7533 Torresdale Avenue, Philadelphia, PA 19136.

10. WILLIAM C. DILLON is a citizen of the United States and the Commonwealth of Pennsylvania who resides at 469 East Maple Avenue, Langhorne, Pennsylvania 19047. This action is brought by PAULINE DILLON, Guardian and Next Friend to WILLIAM C. DILLON. PAULINE DILLON resides at 732 15th Avenue, Prospect Park, Pennsylvania 19076.

11. TERRENCE ERVINE is a citizen of the United States and the State of New Jersey who resides at 8 Burgundy Drive, Marlton, New Jersey 08053.

12. LISA LEX is a citizen of the United States and the Commonwealth of Pennsylvania who resides at 398 Newark Road, West Grove, PA 19390.

13. CHARLES MATTHEWS is a citizen of the United States and the State of Delaware who resides at 100 Orchard Lane, Wilmington, Delaware 19809.

14. SUSAN HANSEN is a citizen of the United States and the Commonwealth of Pennsylvania who receives mail at P.O. Box 232, Narberth, PA 19072.

15. The PHILADELPHIA AREA PROJECT ON OCCUPATIONAL SAFETY AND HEALTH (PhilaPOSH), is a non-profit organization comprised of individuals and more than 2000 unions, representing approximately 300,000 workers in Southeastern Pennsylvania. PhilaPOSH advocates for occupationally safe workplaces and for the advancement of the rights of workers who have been injured in workplace accidents, through occupational disease, and other workplace hazards. Many PhilaPOSH members are injured workers who have been directly affected by the utilization review procedures at issue in this case, and who are potentially subject to the future loss of benefits pursuant to those provisions. PhilaPOSH maintains its principal place of business at 3001 Walnut Street, Philadelphia, PA 19104.

16. The PHILADELPHIA FEDERATION OF TEACHERS, LOCAL 3, AFL-CIO (PFT), is an unincorporated labor organization within the meaning of § 301(3) of the Public Employe Relations Act of 1970, P.L. § 63, No. 195 ("Act 195"), 43 P.S. § 1101.301(3) and is located at 1816 Chestnut Street, Philadelphia, PA 19103. The PFT represents ten (10) bargaining units consisting of approximately 20,000 professional and non-professional employees of the School District of Philadelphia for the purpose of collective bargaining. The PFT and the School District of Philadelphia are parties to a collective bargaining agreement whose terms and provisions expire on August 31, 1996. The PFT was permitted to intervene as a plaintiff in this litigation by order of the court dated March 30, 1995.

Plaintiffs-Class

17. The above-named plaintiffs bring this action on their own behalf, and on behalf of all other persons similarly situated, pursuant to Rules 23(a) and (b)(2) of the Federal Rules of Civil Procedure. The class represented by the named plaintiffs

consists of all persons who have been, or will be in the future, receiving medical benefits pursuant to the Pennsylvania Worker's Compensation Law, and who have had or will have their medical benefits superseded pursuant to Section 306(f.1)(5) without advance notice and an opportunity for an evidentiary hearing, at a meaningful time and in a meaningful manner, and whose right to have those benefits restored is thereafter adjudicated pursuant to the provisions of 306 (f.1)(6).

Defendants - Individual

18. JOHNNY J. BUTLER is the Secretary of the Department of Labor and Industry for the Commonwealth of Pennsylvania.[1] In his capacity as Secretary, Mr. Butler is charged with the legal responsibility to administer and enforce the laws of the Commonwealth of Pennsylvania relating to workers' compensation. Pursuant to Section 401.1 of the Pennsylvania Workers' Compensation Act, as amended, 77 P.S. § 710 (1992), the Department of Labor and Industry is statutorily charged with the duty to:

i. Enforce time and other performance standards so as to insure the prompt processing of injury claims and the payment of compensation when due;

ii. Appoint Workers' Compensation Judges;

iii. Hear and determine all claims and other petitions, including petitions to suspend, modify or terminate the payment of benefits resulting from prior agreement or judicial order;

iv. Adopt rules and regulations necessary for the enforcement of the Workers' Compensation Act.

19. As Secretary of the Pennsylvania Department of Labor and Industry, defendant Butler sits as one of the three members of the State Workers' Insurance Board which administers the

[1] Mr. Butler is hereby substituted for Robert C. Barnett, who was named in the original complaint, pursuant to Rule 25(d) of the Federal Rules of Civil Procedure.

daily operations of the defendant State Workers' Insurance Fund ("SWIF"). 77 P.S. § 211.

20. RICHARD A. HIMLER is the Executive Director of the Pennsylvania Bureau of Workers' Compensation.[2] As Executive Director, defendant Himler is charged with the duties and responsibilities of administering the Pennsylvania Workers' Compensation Act.

21. CONSTANCE B. FOSTER and CATHERINE BAKER KNOLL are, respectively, the Insurance Commissioner and Treasurer for the Commonwealth of Pennsylvania. Pursuant to 77 P.S. § 211, the State Insurance Commissioner and State Treasurer sit on the State Workers' Insurance Board, which is statutorily charged with the duty to administer the operations of defendant SWIF.

22. JOHN P. O'MALLEY is the Director of the STATE WORKERS' INSURANCE FUND ("SWIF"). SWIF was created pursuant to 77 P.S. § 221, in order to provide insurance coverage against potential liability arising under the Pennsylvania Workers' Compensation Act to contributing employers. SWIF is required to insure all risks, including those employers rejected or cancelled by private insurance companies. SWIF, like the private insurance carriers and the self-insuring employers named below, is governed by and subject to the substantive and procedural sections of the Pennsylvania Workers' Compensation Act.

Defendants-Class

23. AMERICAN MANUFACTURERS' MUTUAL INSURANCE COMPANY is an insurance carrier licensed to do business in the Commonwealth of Pennsylvania, and specifically authorized to issue workers' compensation coverage within the

[2] Mr. Himler is hereby substituted for Frank Beal, who was named in the original complaint, pursuant to Rule 25(c) of the Federal Rules of Civil Procedure.

Commonwealth. Its principal place of business is Ten Independence Mall, Philadelphia, PA 19106.

24. CIGNA CORPORATION is an insurance carrier licensed to do business in the Commonwealth of Pennsylvania, and specifically authorized to issue workers' compensation coverage within the Commonwealth. Its principal place of business is 1650 Market Street, Philadelphia, PA 19103.

25. COMMERCIAL UNION INSURANCE COMPANY is an insurance carrier licensed to do business in the Commonwealth of Pennsylvania, and specifically authorized to issue workers' compensation coverage within the Commonwealth. Its principal place of business is 200 Foxboro Street, Suite 400, Foxborough, Massachusetts.

26. CONTINENTAL CASUALTY INSURANCE COMPANY (also known as CNA) is an insurance carrier licensed to do business in the Commonwealth of Pennsylvania, and specifically authorized to issue workers' compensation coverage within the Commonwealth. Its principal place of business is 401 Penn Street, Reading, Pennsylvania.

27. DONEGAL MUTUAL INSURANCE COMPANY is an insurance carrier licensed to do business in the Commonwealth of Pennsylvania, and specifically authorized to issue workers' compensation coverage within the Commonwealth. Its principal place of business is 1195 River Road, Marietta, Pennsylvania.

28. HARTFORD MUTUAL INSURANCE COMPANY is an insurance carrier licensed to do business in the Commonwealth of Pennsylvania, and specifically authorized to issue workers' compensation coverage within the Commonwealth. Its principal place of business is 1515 Market Street, Philadelphia, Pennsylvania.

29. USF&G is an insurance carrier licensed to do business in the Commonwealth of Pennsylvania, and specifically authorized to issue workers' compensation coverage within the

Commonwealth. Its principal place of business is 930 Harvest Drive, Suite 400, Blue Bell, Pennsylvania 19422.

30. ZURICH AMERICAN INSURANCE COMPANY is an insurance carrier licensed to do business in the Commonwealth of Pennsylvania, and specifically authorized to issue workers' compensation coverage within the Commonwealth. Its principal place of business is 401 Route 73, Marlton, New Jersey 08053.

31. The SCHOOL DISTRICT OF PHILADELPHIA is an employer as defined in the Pennsylvania Workers' Compensation Act, 77 P.S. § 221. The School District of Philadelphia has a special state certification as a self-insurer, thus exempting it from having to obtain workers' compensation liability insurance, pursuant to Section 305 of the Pennsylvania Workers' Compensation Act, as amended, 77 P.S. § 501. Its principal place of business is located at 21st Street and Benjamin Franklin Parkway, Philadelphia, Pennsylvania 19103.

32. The defendant class consists of all insurance companies, mutual associations, self-insured employment establishments, and all others authorized to insure the payment of worker's compensation benefits within the Commonwealth of Pennsylvania and who have relied on or will rely on Section 306(f.1)(5) of the Pennsylvania Workers' Compensation Act to supersede payment of medical benefits to a recipient without advance notice or the opportunity for a hearing prior to the cessation of those benefits, and who continue to withhold those benefits during the pendency of the utilization review process pursuant to Sections 306(f.1)(5) and (6).

IV. CLASS ACTION ALLEGATIONS

33. This case is properly maintainable as a class action pursuant to Rule 23(b) of the Federal Rules of Civil Procedure.

34. The class consists of more than 40,000 workers' compensation recipients who have had their medical benefits stopped pursuant to Section 306(f.1)(5) of the Pennsylvania

Workers' Compensation Act. Joinder of the affected class plaintiffs would be impracticable.

35. Questions of law and fact are common to the class, those being whether the superseding of workers' compensation medical benefits pursuant to Section 306(f.1)(5) without notice or opportunity to be heard, the withholding of those benefits throughout the pendency of the utilization review process, and the procedures utilized during utilization review pursuant to Section 306(f.1)(6), deprives plaintiffs of property without due process of law.

36. The claims of the named plaintiffs and the defenses of the named defendants are typical of the claims and defenses of the classes they represent.

37. The named plaintiffs and defendants will fairly and adequately protect the interests of their respective classes because, inter alia,

a) the named plaintiffs and defendants represent the same interests as do members of their respective classes;

b) the named plaintiffs and defendants have no interest antagonistic to any member of their respective classes;

c) the named plaintiffs will vigorously prosecute their claims on behalf of the class they seek to represent and it is expected that the named defendants will likewise do so;

d) the named plaintiffs' attorneys are experienced and qualified at handling complex class actions of this type.

38. The named and class defendants' class have acted, or refused to act, on grounds applicable to the plaintiff class, thereby making declaratory, injunctive, and other equitable relief appropriate with respect to the plaintiff class as a whole.

V. STATEMENT OF FACTS

39. The Pennsylvania Workers' Compensation Act of June 2, 1915, P.L. 726, as amended, 77 P.S. § 1 et seq. (Supp. 1993) (hereinafter referred to as "the Act"), is a statute of

statewide applicability. Its purpose is to substitute a state-regulated insurance system which provides a reasonable compensation for injuries to employees arising in the course of their employment for the common law rights and liabilities of employees and employers.

40. The Act requires employers to obtain insurance or to seek permission from the state to self-insure, so as to guarantee the availability of sufficient funds to pay eligible workers' benefits pursuant to a statutory formula. Employers who do not self-insure may insure the payment of workers' compensation benefits with the Commonwealth-administered SWIF, or with any other insurance company or mutual association authorized to insure such liability in the Commonwealth, 77 P.S. § 501.

41. SWIF is required to insure all risks including those rejected or cancelled by private carriers.

42. The employer and/or insurer are required to promptly investigate each industrial injury reported or known to the employer, and within 21 days from the date reported, either:

a) enter into an agreement which requires the payment of compensation;

b) commence the payment of compensation pursuant to a Notice of Compensation Payable; or

c) notify the employee or his dependent on a prescribed form that it is the employer's/insurer's opinion that compensation is not payable.

43. The Department of Labor and Industry, upon being notified by the employer of the employer's intention to controvert the payment of compensation, is required to notify the injured employee of his right to file a claim petition with the Department of Labor and Industry. Subsequently, the Department assigns each claim petition to a state workers' compensation judge.

44. All agreements and awards may be modified, suspended, reinstated, or terminated at any time by an agreement

or supplemental agreement, as the case may be, if the incapacity of the injured employee has increased, decreased, reoccurred, terminated, or changed in any other way.

45. All such agreements and/or supplemental agreements must be sent to the Pennsylvania Department of Labor and Industry which, through its Bureau of Workers' Compensation (hereafter "the Bureau"), examines such documents to determine whether each agreement or supplemental agreement, as the case may be, conforms with the provisions of the Act and the rules and regulations promulgated thereunder.

46. In the absence of an agreement or supplemental agreement, the employer/insurer must petition the Department of Labor and Industry in order to suspend, terminate, reduce or otherwise modify any agreement or award of compensation. This applies both to wage loss benefits and to medical benefits payable under the Act.

47. As a result of a decision by a three-judge court in Baksalary v. Smith, 579 F. Supp. 218 (E.D. Pa. 1984), employers or insurance companies seeking to cease workers' compensation benefits pending litigation over the right to terminate, suspend, or reduce benefits, is required to seek a discretionary supersedeas from a workers' compensation judge which can be granted or denied after a hearing at which recipients have an opportunity to be present and give evidence.

48. Prior to Baksalary, employers and insurers were entitled to automatically cease wage loss and medical benefits upon the filing of a petition with the Bureau accompanied by a physician's affidavit of recovery pursuant to Section 413(a) of the Act.

49. Baksalary declared the automatic supersedeas procedure contained in Section 413(a) to be unconstitutional and enjoined its further use.

50. On July 2, 1993 Act 44 was passed by the Pennsylvania Legislature, containing several amendments to the Pennsylvania Worker's Compensation Act intended to contain

workers' compensation costs. It became effective on August 31, 1993.

51. Act 44 contained provisions, now known as Sections 306(f.1)(5) and (6), for utilization review of the reasonableness and necessity of medical treatment, which like the invalidated Section 413(a), operates as an automatic supersedeas of workers' compensation medical benefits upon the filing of a petition with the Bureau by the insurer or employer.

52. Like the invalidated Section 413(a), no notice to the claimant or his/her attorney is required to be provided to the recipient prior to the cessation of benefits.

53. Like the invalidated Section 413(a), the utilization review procedure contained in Section 306(f.1)(5) provides no opportunity for the claimant or his/her counsel to be heard prior to the cessation of benefits.

54. Pursuant to Section 306(f.1)(5), an insurer or self-insured employer may seek utilization review of the reasonableness and necessity of current, prospective, or retrospective medical treatment.

55. There is no penalty for an insurer or self-insured employer who invokes the utilization review process unreasonably.

56. The Bureau administers all requests for utilization review, acting as a "traffic cop" for the entire process.

57. Each request for utilization review is made by filing a petition with the Bureau on a form designed and approved by it.

58. The Bureau screens all petitions for utilization review for conformity with Section 306(f.l)(5) and (6) and assigns them to a utilization review organization certified by the Department of Labor and Industry. Any petition found not to be in conformity is returned to the petitioner with specific instructions.

59. The period between the filing for utilization review and assignment by the Bureau to a URO may encompass several weeks or even months.

60. At the time of the assignment to the URO, the Bureau forwards a Notice of Assignment to the recipient, the employer, and the medical provider under review.

61. Neither the Request for Utilization Review nor the Notice of Assignment notify the claimant that pursuant to the request or its assignment, payment for his or her medical benefits will be stopped pending the review.

62. The provider under review is given an opportunity to discuss the challenged treatment with the URO.

63. There is no opportunity for the recipient or his counsel to be heard by the URO or to submit evidence supporting the recipient's claim for benefits.

64. The Bureau provides no substantive guidance to the URO to define the terms "reasonable and necessary", thus leaving the construction of the standard to be applied to the discretion of the individual URO's.

65. The URO is responsible for rendering a determination within thirty days of receipt of the providers medical records, or sixty days of the assignment, whichever occurs first.

66. This time frame is often not adhered to, causing many claimants to wait more than thirty days for a decision during which most are without access to medical care due to the employer/insurer's right to supersede payment.

67. The URO must file its report with the Bureau, along with a Bureau-designed face sheet, and mail copies to all involved parties.

68. A party dissatisfied with the outcome of a utilization review may file for reconsideration with the Bureau on a form prepared by the Bureau within thirty days of the initial decision.

69. The Bureau will review the form for compliance with the statute, and assign the case for disposition by a URO certified by the Department of Labor and Industry.

70. The period between the filing for reconsideration and assignment by the Bureau to a URO may encompass several weeks, or even months.

71. Even if the claimant receives a favorable decision from the initial URO, the supersedeas of his/her medical benefits remains in effect if the employer requests reconsideration.

72. Although the claimant receives a copy of the employer/insurer's request for reconsideration, and the Notice of Assignment issued by the Bureau, neither document notifies the claimant that his/her benefits will be suspended throughout the pendency of the request for reconsideration.

73. During reconsideration, the provider of medical services is extended an opportunity to discuss the treatment under review, but no opportunity to be heard or to submit evidence is afforded the recipient or his counsel.

74. A claimant who seeks reconsideration unsuccessfully is liable for payment of the URO's expenses.

75. Likewise, if reconsideration of an initial utilization review decision which was favorable to the claimant is sought by the insurance company or employer, and the decision is reversed on reconsideration, the claimant is liable for payment of the URO's expenses.

76. Neither the Request for Reconsideration nor the Notice of Assignment notify the claimant that he will be liable for the URO's expenses if he does not prevail on reconsideration.

77. The cost of utilization review at the reconsideration level is not fixed by the Bureau, but is left to the discretion of the individual URO. The typical charge involves several hundred dollars.

78. There is no in forma pauperis procedure to excuse indigent claimants from the assessment of the reconsideration fee.

79. The Bureau takes collection action against a claimant for the reconsideration fee notwithstanding the claimant's ability or inability to pay.

80. The fee is assessed against the claimant as the "losing party" without any opportunity for the claimant to be heard as to the reasonableness and necessity of the medical treatment under review.

81. In the event that a recipient is dissatisfied with the URO decision on reconsideration, he/she may file a Petition for Review with the Bureau within thirty days on a form prepared by the Bureau.

82. During the pendency of the Petition for Review filed by a claimant, the supersedeas of the claimant's medical benefits remains in effect.

83. If the claimant prevails on reconsideration, the supersedeas is lifted, even if the employer files a Petition for Review.

84. The Bureau reviews all Petitions for Review for compliance with the statute, and assigns the petition to a workers' compensation judge for a de novo hearing.

85. A claimant is not eligible for a hearing before a workers' compensation judge unless he/she first seeks reconsideration and risks assessment of the utilization review fee.

86. Proceedings before the workers' compensation judge may extend for several months and claimants may await a decision for several months or even years.

87. The Bureau has promulgated no regulations setting forth how workers' compensation judges are to handle petitions for review from utilization review reconsideration decisions.

88. Accordingly, procedures for the determination of petitions for review vary widely according to the individual discretion of the assigned judge, as to who has the burden of proof, what evidence will be allowed, the type and extent of hearing provided, whether the utilization review decisions will be permitted as evidence or whether the utilization reviewer will be permitted to testify, whether the claimant will be required to undergo a medical examination, whether depositions will be required, and a variety of other procedural matters.

89. The withholding of medical benefits during the utilization review process can be very prolonged, extending months or years during completion of the utilization review process.

90. For many workers' compensation recipients whose medical benefits are unilaterally terminated pursuant to Section 306(f.1)(5) and (6), pain, prolonged recuperation, and/or other medical complications result.

91. Throughout the utilization process, however long it takes, the claimant is not permitted to pay for medical treatment him or herself either directly or through medical insurance from another source, and is thus precluded from seeking or securing medical treatment altogether.

VI. THE NAMED PLAINTIFFS

DELORES SCOTT SULLIVAN

92. Delores Scott Sullivan worked as a Secretary for a workers' compensation judge for the Pennsylvania Department of Labor and Industry.

93. On February 26, 1991, Ms. Sullivan notified her employer that she was suffering pain in her hands, arms, and her neck which she believed to be work related.

94. She continued to work until October 12, 1992, but sought medical treatment in the meantime, rendering a diagnosis of cumulative trauma disorder and disc herniation in the neck.

95. Ms. Sullivan began receiving wage replacement and medical benefits via workers' compensation pursuant to a Notice of Compensation Payable dated February 5, 1993.

96. On March 18, 1992, SWIF, on behalf of the Department of Labor and Industry, filed a petition seeking review of the medical benefits Ms. Sullivan was receiving pursuant to her workers' compensation and requested a supersedeas.

97. On July 13, 1993, Workers' Compensation Judge John Liebau entered an order denying SWIF's request for supersedeas.

98. SWIF filed for utilization review of the treatment Ms. Sullivan was receiving from Dr. Kenneth L. Izzo and the Pain Management and Rehabilitation Center.

99. Pursuant to that request and without notice to Ms. Sullivan, SWIF unilaterally terminated payment for Ms. Sullivan's medical treatment.

100. Ms. Sullivan was afforded no opportunity to be heard prior to the cessation of her medical benefits.

101. On April 20, 1994, a decision was rendered by Rehabilitation Planning, Inc., the URO assigned by the Bureau to consider the request, finding the treatment under review to be unnecessary.

102. Through counsel, Ms. Sullivan filed for reconsideration on May 15, 1994.

103. An adverse decision was rendered by the URO on reconsideration on September 20, 1994.

104. On October 7, 1994, a petition for review was filed on Ms. Sullivan's behalf by her attorney. That petition is presently pending.

105. Since SWIF unilaterally terminated Ms. Sullivan's medical benefits she has been unable to secure medical treatment for her condition.

106. Due to the actions of SWIF and the state defendants Ms. Sullivan has been without relief for the pain in her hands, neck, and back, has experienced an exacerbation of her symptoms due to the lack of treatment, has been unable to procure medication, and has suffered emotional distress.

WILLIAM BATTLE

107. William Battle was a laborer for ITW Philadelphia Resins when on December 9,1992 he was hit in the head with a 300 pound pot when the skid upon which it was resting broke.

108. Mr. Battle suffered two herniated discs in his neck and two bulging discs in his back as a result of this accident.

109. Mr. Battle began receiving workers' compensation benefits in January of 1993.

110. In August, 1993, American Manufacturers' Mutual Insurance Company filed a petition to terminate Mr. Battle's workers' compensation benefits.

111. The insurer requested a discretionary supersedeas from the workers' compensation judge, which was denied on March 9, 1994. The Judge ordered the defendant to "continue to pay claimant's weekly benefits and reasonable and necessary medical expenses incurred in connection with Claimant's injury of December 9, 1992".

112. On or about April 5, 1994, the insurer filed a three requests for utilization review of all medical treatment being provided for Mr. Battle.

113. Upon the filing of those requests and without notice to Mr. Battle, the insurer ceased paying for any medical treatment for the injuries sustained by Mr. Battle in his December, 1992 work-related accident.

114. Mr. Battle was afforded no opportunity to be heard prior to the cessation of his benefits.

115. The utilization review requests were decided adversely to Mr. Battle upon initial review and again on reconsideration.

116. Petitions for Review were filed in August, September, and November of 1994. All three are presently awaiting decision by the Workers' Compensation Judge.

117. As a result of the insurer's unilateral action, no treatment bills have been paid since April 5, 1994, and Mr. Battle is unable to obtain the treatment he requires to treat his disabling symptoms.

118. The actions of defendant American Manufacturers Mutual in conjunction with the state defendants have caused Mr. Battle to experience increased pain, reduced mobility, and emotional distress.

LOUIS BAUMGARTNER

119. Louis Baumgartner was employed at Dan's Farm Fresh Poultry on March 22, 1989, when he fell as he was unloading a box of frozen chicken from a truck.

120. Mr. Baumgartner sustained injuries to his back, elbows, and head during this accident.

121. Mr. Baumgartner began receiving workers' compensation benefits on April 20, 1989 pursuant to a Notice Of Compensation Payable issued by Donegal Mutual Insurance Company (hereafter "Donegal").

122. The injuries to Mr. Baumgartner's elbows and back were permanent, and he was therefore foreclosed from returning to the type of work he did prior to his accident.

123. In July of 1990 Mr. Baumgartner returned to the workforce as a security guard. He is so employed at the present time on a part-time basis, earning $5.00 per hour.

124. As a result of the injuries he sustained in his 1989 accident, Mr. Baumgartner still experiences constant pain in his back and has bilateral neuropathy in both hands.

125. Mr. Baumgartner has been receiving chiropractic treatments two times per week which help to control the pain and permit him to function. Without those treatments Mr. Baumgartner would be unable to work at all.

126. On August 29, 1995 Donegal Mutual Insurance Company filed a Request for Utilization Review, challenging the reasonableness and necessity of the chiropractic treatments which Mr. Baumgartner had been receiving from August 31, 1993 to the present.

127. At that time, Donegal stopped paying for Mr. Baumgartner's chiropractic treatment.

128. Mr. Baumgartner received a decision from the URO which found the treatment he had received after September 26, 1995, but not before, to be unreasonable and unnecessary.

129. Mr. Baumgartner filed a Request for Reconsideration on November 20, 1995.

130. Mr. Baumgartner received no notice that he might be liable for the payment of the URO's expenses if he did not prevail on reconsideration.

131. On January 10, 1996 Mr. Baumgartner received a decision from the URO finding the treatment he had received from August 31, 1993 and ongoing was unreasonable and unnecessary.

132. Mr. Baumgartner filed a Petition for Review on February 2, 1996, which is presently pending before a Workers' Compensation Judge.

133. A penalty petition was also filed pertaining to the monies owing to the chiropractor during the time frame found to be reasonable and necessary by the first URO. Those bills, totalling $1223.98, were ultimately paid by Donegal.

134. Meanwhile, on February 8, 1996, the Bureau sent Mr. Baumgartner a bill for $525.00, representing the URO's expenses on reconsideration.

135. Mr. Baumgartner's attorney wrote to the Bureau contesting the fee because Mr. Baumgartner had been deemed to be the "losing party" without a hearing, and further, because Mr. Baumgartner cannot afford to pay the bill. Mr. Baumgartner's attorney requested *in forma pauperis* status for him.

136. The Bureau responded by letter dated March 4, 1996 that "[t]here is no hearing process" on this matter, and advised Mr. Baumgartner's attorney to contact David Weyl, Chief of Medical Cost Containment, if he disagreed with Bureau's position.

137. By letter dated April 2, 1996 Mr. Baumgartner's attorney wrote to Mr. Weyl requesting a hearing and also requesting in forma pauperis status for Mr. Baumgartner due to his financial condition.

138. Mr. Weyl responded in a letter dated April 16, 1996 that under the Bureau's regulations, Mr. Baumgartner is the "liable party", and is therefore responsible for the payment of the URO's expenses.

139. Donegal has made no payments to Mr. Baumgartner's chiropractor since the date of its initial Request for Utilization Review.

140. Mr. Baumgartner has been receiving the chiropractic treatments which he needs to maintain his functional ability to work only because his chiropractor has provided him the treatments without demanding payment.

ANTHONY CANCILA

141. Anthony Cancila was employed as a plumber for Temple University Hospital when he began experiencing extreme back pain in April of 1988.

142. Shortly thereafter he was forced to leave his employment as a result of his pain.

143. Two damaged discs were found in his back and Mr. Cancila underwent spinal fusion in an effort to reduce his symptoms.

144. Mr. Cancila began receiving workers' compensation benefits from CIGNA pursuant to a Notice of Compensation Payable on May 3, 1988.

145. Mr. Cancila had received little relief from the therapies he had received in 1990 and 1991 for his back condition, including the surgery, and has experienced continued incapacity which permanently precludes his return to the plumbing trade.

146. In August of 1993 CIGNA petitioned the Bureau of Workers' Compensation to terminate Mr. Cancila's workers' compensation benefits on the assertion that he was able to return to work.

147. A supersedeas hearing was held on January 10, 1994, at which CIGNA presented evidence in support of its request.

148. On February 7, 1994, Judge Joseph E. Hagen determined that CIGNA had presented inadequate evidence to justify the supersedeas request and entered an order denying the supersedeas and ordering defendant to pay claimant's weekly benefits and reasonable and necessary medical expenses.

149. Meanwhile, the plaintiff began physical therapy at the Philadelphia Center for Aquatic Rehabilitation, which provided great relief from his pain.

150. Subsequent to the supersedeas decision, on April 26, 1994, CIGNA filed a petition for utilization review of physical therapy services retroactive to March 1, 1994, and stopped paying for the aquatic therapy.

151. The Philadelphia Center for Aquatic Rehabilitation provided services to Mr. Cancila through the month of June, 1994 without payment, but terminated services at that time due to non-payment by CIGNA.

152. Since that time, Mr. Cancila has had no access to the therapy he needs for pain relief.

153. The actions of CIGNA, in conjunction with the Commonwealth defendants, have caused Mr. Cancila to suffer an exacerbation of pain and his physical symptoms, and emotional distress.

CHRISTOPHER COSTELLO

154. Christopher Costello worked as a roofer for the H. Aronow Roofing Company when he suffered severe burns on his hand as a result of a hot asphalt spill on June 11, 1990. During the accident Mr. Costello suffered several falls, resulting in injury to his back and arms as well.

155. Mr. Costello began receiving compensation benefits from USF&G Insurance Company pursuant to a Notice of Compensation Payable dated July 5, 1990.

156. Mr. Costello began receiving medical treatment for his injuries and was diagnosed with bilateral C6 radiculopathy, right and left carpal tunnel syndrome and right and left ulnar neuropathy. He eventually developed nerve compressions in his right and left arms.

157. Dr. Greene recommended that Mr. Costello undergo surgery on his right arm to curb the nerve damage which he suffered as a result of his accident, and to prevent further and probably permanent damage from occurring.

158. USF&G refused to provide clearance for the surgery.

159. On November 23, 1993, USF&G filed a petition for utilization review challenging Mr. Costello's right to further orthopedic treatment and possible surgery, retroactive to September 1, 1993.

160. Without notice to Mr. Costello and pursuant to the petition for utilization review, USF&G unilaterally terminated payments to Dr. Greene.

161. Mr. Costello was afforded no opportunity to be heard prior to the cessation of his benefits.

162. The Bureau referred the petition to Independent Medical and Dental Consultants, Inc. for disposition, which rendered a decision in Mr. Costello's favor.

163. On March 7, 1994, USF&G filed a Request for Reconsideration, which the Bureau assigned to OMNI Medicorp Ltd. for disposition.

164. On April 8, 1994, the URO issued a decision finding ongoing treatment for Mr. Costello's injuries and surgery for those injuries to be unreasonable.

165. Through counsel, a Petition for Review of the URO Determination was filed on April 27, 1994, and is presently pending before the Workers' Compensation Judge.

166. As a result of USF&G's unilateral termination of Mr. Costello's medical benefits he has been unable to procure the surgery he needs, thus hampering his rehabilitation and prolonging his disability.

167. The actions of defendant USF&G, acting in conjunction with the state defendants, have caused Mr. Costello to suffer prolonged disability and permanent physical damage, to endure unnecessary pain, and have caused him emotional distress.

WILLIAM C. DILLON, by his Guardian and Next Friend, PAULINE DILLON

168. William C. Dillon was employed by CH Schwertner & Sons on September 29, 1981, when he was injured during a scaffolding accident.

169. Mr. Dillon fell forty feet and suffered traumatic brain injuries, cervical fracture, spinal cord injury, frontoparietal fracture and hematoma, lwtort III fracture, hemothorax mandibular fracture, fracture subluxation of C1 and C2 and quadriparesis, as well as right eye blindness, cognitive dysfunction an significant hearing loss.

170. Mr. Dillon remained in a coma for a year and a half after the accident, during which time he received custodial care at the Haverford Nursing Center.

171. Mr. Dillon emerged from his coma on February 16, 1983 and shortly thereafter was transferred to the Lewis Bay Brain Center in Hyannis, Massachusetts.

172. Mr. Dillon received extensive rehabilitative therapy in this facility, and learned to talk, feed himself, and use the bathroom on his own, among other things.

173. Since the Brain Center was a short term facility, Mr. Dillon was moved after six months to the Paoli Nursing Home, where he received only custodial care.

174. Under a custodial regime Mr. Dillon began to regress in many of the skills he had re-acquired during his rehabilitation at the Lewis Bay Brain Center.

175. Mr. Dillon was ultimately moved to the Beechwood Rehabilitation Center where he has resided since 1986.

176. Beechwood has a comprehensive rehabilitation program which has permitted Mr. Dillon to achieve a level of independence which he could not have achieved and cannot maintain without such therapy.

177. On October 12, 1996 Commercial Union Insurance Company (hereafter "Commercial Union"), filed a request for utilization review of all active rehabilitation which Mr. Dillon was receiving retroactive to August 1, 1995.

178. Based upon the filing of the request for utilization review, Commercial Union reduced the monthly payments it was making to Beechwood to reflect what it deemed to be the appropriate rate for a residential facility which provides custodial care and no active rehabilitation.

179. The URO, Worldwide Auditing Services, received the request on October 20, 1996 and rendered a decision against Mr. Dillon on November 30, 1996.

180. The basis for the URO's decision was that the rehabilitation which Mr. Dillon was receiving was not reasonable and necessary because his condition is not amenable to further improvement.

181. A Request for Reconsideration on his behalf on December 1, 1995.

182. Ms. Pauline Dillon, Mr. Dillon's mother, was appointed as Mr. Dillon's legal guardian by order of the Delaware County Orphan's Court on April 29, 1982, and has served in that capacity since that time.

183. Ms. Dillon received no notice that she would be assessed a fee if she did not prevail on reconsideration.

184. An adverse reconsideration decision was rendered by the URO on or about January 19, 1996.

185. On or about February 5, 1996, Mr. Dillon received a bill from the Bureau notifying him that he was the "losing party" and informing him that as such, he was responsible for the payment of the URO's expenses upon reconsideration, totalling $545.00.

186. Mr. Dillon's attorney filed a Petition for Review on February 12, 1996 challenging the decisions of the URO.

187. That decision is presently pending.

188. Meanwhile, Beechwood has informed Mr. Dillon that he will have to be removed from the facility due to the reduction in payment which it has been receiving from Commercial Union on his behalf.

189. Mr. Dillon's treating physicians characterize Mr. Dillon's need for continuing rehabilitation services as urgent, because without them he will be unable to maintain the level of functioning that he has been able to acquire with the therapy.

TERRENCE ERVINE

190. Terrence Ervine was working as a bus boy for the Hilton Hotel when he slipped on grease on the restaurant floor and sustained permanent injuries to his neck and back on November 17, 1978.

191. Mr. Ervine began receiving workers' compensation benefits shortly thereafter.

192. Mr. Ervine's injuries prevented him from ever going back to the type of work he was doing at the Hilton at the time of his injury. Accordingly, he went back to school for retraining.

193. As of October 15, 1982 Mr. Ervine was able to go back to work, and agreed to suspend his workers' compensation wage benefits via a supplemental agreement. Under the terms of the suspension, Mr. Ervine would continue to receive treatment for the residual effects of the work injuries which he sustained in 1978.

194. Mr. Ervine has continued to work since the execution of his supplemental agreement, and is presently maintaining a business of his own. However, he has required physical therapy and other treatments in order to maintain the physical capability to perform his job.

195. On December 12, 1993 the Hartford Insurance Company filed a request for utilization review for the chiropractic services which Mr. Ervine had been receiving.

196. A second request for utilization review was filed on June 13, 1994 challenging the physical therapy services which Mr. Ervine was receiving for his work related disability.

197. Initial decisions were rendered on May 27, 1994 and August 19, 1994, respectively, both of which were in favor of the insurer.

198. Mr. Ervine sought Reconsideration as to both decisions on June 9, 1994 and July 1994, respectively.

199. A Reconsideration decision was issued on September 30, 1994 finding the physical therapy Mr. Ervine had been receiving to be unreasonable and unnecessary.

200. A reconsideration decision in favor of the employer was issued as to chiropractic care on March 10, 1995.

201. Timely petitions for review were filed as to both utilization reviews and are awaiting decision by the workers' compensation judge assigned to the case.

202. Since the time of the initial request for utilization review challenging the chiropractic treatment, Hartford has superseded payments of all medical services which Mr. Ervine had been receiving.

203. Since the initial request for utilization review challenging Mr. Ervine's physical therapy, he has been able to receive physical therapy for his injury only because his doctor has been kind enough to treat him without demanding payment.

204. Mr. Ervine requires the treatment in order to keep his pain under control and maintain his level of functioning. Without the treatment Mr. Ervine would be unable to maintain his business.

LISA LEX

205. On December 8, 1986, Lisa Lex worked as a sales person at Macy's Department Store when she suffered a twisting injury to her spine while lifting a forty-five pound package of stoneware.

206. As a result of her injury, Ms. Lex sustained permanent nerve damage to her neck and right hip and leg.

207. As a result of her injuries, Ms. Lex has been unable to resume her employment in retail sales.

208. On March 2, 1992, Ms. Lex entered into a settlement with Zurich American Insurance Company in which she agreed to accept a lump-sum in full compromise of her lost

wage claim, and the insurance company in turn agreed to provide ongoing medical care for Ms. Lex's residual symptoms.

209. At the time of the settlement and since then, Ms. Lex has suffered constant pain in her right hip with radiation through her right leg. She has carpal tunnel syndrome in both hands.

210. Ms. Lex has been undergoing weekly physical therapy prescribed by her physician to reduce the functional impact of her injuries.

211. Although the therapy cannot cure her condition, it has provided symptomatic relief which has enabled her to return to work in a sedentary job.

212. Since September 15, 1992, Ms. Lex has been employed by Skyvision Cable as a Customer Service Representative.

213. On March 3, 1994, Zurich American Insurance Company filed for utilization review of Ms. Lex's physical therapy and unilaterally stopped paying for her treatments. The petition was assigned by the Bureau on April 7, 1994.

214. Neither Ms. Lex nor her counsel were given advance notice that medical benefits would be stopped, and neither were provided an opportunity to be heard as to the propriety of the cessation of those benefits.

215. A URO determination adverse to Ms. Lex was rendered on June 14, 1994.

216. Ms. Lex's treating physician, Dr. Robert Smith, filed for reconsideration on June 20, 1994.

217. The Bureau assigned the Request for Reconsideration on September 9, 1994.

218. A decision adverse to Ms. Lex was rendered on October 17, 1994.

219. Ms. Lex's attorney was not timely apprised of the outcome of the reconsideration by either the doctor or the URO. Accordingly, no appeal could be filed.

220. On December 1, 1994, as a result of the unpaid medical bills for treatments rendered to Ms. Lex from March, 1994 to the present, Ms. Lex was informed that her treatments would be stopped.

221. The actions of defendant Zurich, acting in concert with the state defendants, have caused Ms. Lex to suffer increased pain, enhanced dependence upon medication, reduced functional capacity which threatens her ability to maintain her employment, and emotional distress.

CHARLES MATTHEWS

222. Charles Matthews was working for Manpower at the Westinghouse Trash Facility when he was injured on September 5, 1992 by a 600 pound piece of metal slag which slid down a broken refuse tank.

223. Mr. Matthews suffered, among other injuries, a crushed leg and a medial meniscus tear which required surgery. Since that time, he has developed reflex sympathetic dystrophy in his knee, which has prevented him from regaining use of his leg.

224. Since the accident and as a direct result of it, Mr. Matthews has been confined to a wheelchair.

225. Also as a direct result of his accident, Mr. Matthews has suffered from depression and post traumatic stress disorder.

226. Mr. Matthews has been unable to work since his accident, and has been receiving medical care and wage loss benefits through workers' compensation.

227. Among the services Mr. Matthews was receiving through workers' compensation were attendant care services in his home.

228. On June 22, 1994, CNA Insurance Company (CNA) filed for utilization review of each of the medical services which Mr. Matthews receives, including attendant care services and transportation, and terminated payment for those services without advance notice to him or an opportunity to be heard.

229. On July 5, 1994, Mr. Matthews was attempting to remove the trash from his apartment, a task which had been previously performed for him by the attendant care worker. He lost his balance and fell down a flight of concrete stairs, injuring his legs and shoulder, and experiencing excruciating pain in his damaged leg.

230. Approximately one week later, Mr. Matthews was attempting to enter his kitchen to make lunch, a service which had been previously performed for him by the attendant care worker, and fell again, injuring his right shoulder.

231. The Request for Utilization Review, which had been filed on June 22, 1994, was assigned by the Bureau on July 29, 1994.

232. On September 29, 1994, prior to any decision being rendered by the URO, the insurance carrier withdrew the request for review.

233. On or about the same date, however, CNA refiled the URO, again challenging the attendant care services which Mr. Matthews had been receiving.

234. Upon the withdrawal of the first request for utilization review, the insurance company failed to make any payments encompassed by the time frame of that request.

235. Mr. Matthews ultimately received a favorable determination from the utilization review organization as to the second filing.

236. Another Request for utilization review was filed against Mr. Matthews in approximately October of 1994, this time challenging Mr. Matthews' medical treatment.

237. On December 29, 1994 Mr. Matthews received a favorable decision from the URO, finding the medical treatment he was receiving to be reasonable and necessary.

238. In approximately August of 1995, CNA filed another request for utilization review of the attendant care services Mr. Matthews had been receiving.

239. Again, the treatment was found to be reasonable and necessary.

240. On August 30, 1995, Mr. Matthew's attorney filed a petition on his behalf seeking penalties against CNA because despite the favorable decisions rendered by the various URO's which had reviewed his case, and which were unappealed by the carrier, Mr. Matthew's medical expenses had still not been paid.

241. That petition was ultimately withdrawn when the bills were finally paid.

242. After each request for utilization review, the services which were necessary for Mr. Matthews to travel to his doctors' appointments, receive medical treatment, and secure services in his home were interrupted, placing him at great risk of physical injury, and in some cases led to actual injury, caused him to suffer harassment by medical creditors, and further caused enormous inconvenience and emotional distress.

243. These injuries were produced by the defendant Continental Casualty, acting in conjunction with the state defendants.

SUSAN HANSEN

244. On March 1, 1990, Susan Hansen was working as a long-term substitute teacher for the School District of Philadelphia when she was injured by five pound block of wood which was hurled at her from across the classroom by ten year old student.

245. Ms. Hansen suffered a traumatic thrombophlebitis of the right leg, which eventually produced reflex sympathetic

dystrophy. She has also suffered severe psychological symptoms as a result of her injury and the problems she has encountered as a result of it.

246. Ms. Hansen began receiving workers' compensation benefits pursuant to a Notice of Compensation Payable on April 19, 1990.

247. Ms. Hansen received workers' compensation medical benefits covering orthopedic services, including supervision by her doctor and physical and bio-feedback therapy, and psychological treatment.

248. On July 27, 1992, the School District of Philadelphia, through its benefit administrator, filed a petition to terminate Ms. Hansen's workers' compensation benefits.

249. The District requested a supersedeas of benefits, which was denied by Workers' Compensation Judge John Liebau on September 28, 1992.

250. On October 18, 1993, the District filed a petition with the Bureau for utilization review of the psychological treatment Ms. Hansen was receiving from her psychologist, Dr. Julie Weiss.

251. That petition was assigned by the Bureau to the Delaware Valley Peer Review Organization on December 2, 1993.

252. Pursuant to that petition, the School District unilaterally terminated all payments to Ms. Hansen's psychologist without notice to Ms. Hansen.

253. On January 20, 1994, the URO issued a decision denying further psychological treatment to Ms. Hansen.

254. On February 10, 1994, Ms. Hansen filed a Request for Reconsideration from the first URO decision.

255. On April 28, 1994, another adverse decision was rendered by the reviewing URO.

256. On May 26, 1994, Ms. Hansen, through her attorney requested review of the URO decisions by a workers' compensation judge, but no review date has been set.

257. Since the initial petition for utilization review was filed, Ms. Hansen has been required to pay $90.00 per visit in order to procure the psychological therapy she needs in order to cope with the severe psychological symptoms produced by her work injury.

258. On or about October 18, 1993, the School District filed a petition for utilization review of the orthopedic treatment Ms. Hansen was receiving for treatment of her injured leg, including medical supervision, physical and biofeedback therapy.

259. Pursuant to this petition, and without notice to Ms. Hansen, the School District took an automatic supersedeas of benefits and stopped paying for her orthopedic treatment.

260. On February 25, 1994, the Delaware Valley Peer Review Organization which had been assigned by the Bureau to process the URO request, issued a decision denying Ms. Hansen bio-feedback and physical therapy and reducing her doctors' visits to one time every four to six months.

261. On March 23, 1994, Ms. Hansen requested reconsideration of the initial decision.

262. A second adverse decision was issued on June 7, 1994 by the Bureau-assigned URO, the Villanova Rehabilitation Consultants, Inc.

263. On June 21, 1994, Ms. Hansen, through counsel, filed for Review of the URO decision by a Workers' Compensation Judge. That request is still pending.

264. As a result of the actions of the School District, acting in conjunction with the state defendants, Ms. Hansen has suffered severe pain, financial loss, and emotional distress.

VII. STATEMENT OF CLAIMS

COUNT I:

THE AUTOMATIC SUPERSEDEAS CONTAINED IN SECTION 306(F.1(5) VIOLATES PLAINTIFFS' RIGHT TO PROCEDURAL DUE PROCESS OF LAW

265. Plaintiffs reallege and incorporate by reference all allegations contained in Paragraphs 1 - 264 herein.

266. Named and class defendants, acting under color of state law, and pursuant to Section 306(f.1)(5) of the Pennsylvania Workers' Compensation Act, have superseded workers' compensation medical benefits for which plaintiffs have been previously determined eligible without advance notice and prior opportunity to be seen and heard at an evidentiary hearing.

267. The actions of the defendants were willful, wanton, and in reckless disregard of the plaintiffs' right to due process as articulated in Baksalary v. Smith.

268. As a result, defendants, acting pursuant to Section 306(f.1)(5) of the Pennsylvania Workers' Compensation Act, as amended, 77 P.S. § 531(5) (Supp. 1994), have unlawfully deprived plaintiffs and the members of the class they represent of property in violation of the Due Process Clause of the Fourteenth Amendment to the United States Constitution and 42 U.S.C. § 1983.

COUNT II:

SECTIONS 306(F.1)(5) AND (6) DO NOT PROVIDE PLAINTIFFS WITH AN OPPORTUNITY TO BE HEARD AT A MEANINGFUL TIME IN VIOLATION OF THEIR RIGHT TO PROCEDURAL DUE PROCESS OF LAW

269. Plaintiffs reallege and reincorporate by reference all allegations contained in Paragraphs 1 - 268 herein.

270. Section 306(f.1)(5) and (6) of the Pennsylvania Workers' Compensation Act establishes a system for the supersedeas of medical benefits without a mechanism for

affected plaintiffs to be heard by an impartial factfinder at a meaningful time.

271. As a result, defendants, acting pursuant to color of state law, have deprived plaintiffs and the class they represent of workers' compensation medical benefits in violation of the Due Process Clause of the Fourteenth Amendment to the United States Constitution and 42 U.S.C. § 1983.

COUNT III:

THE ASSESSMENT OF A SUBSTANTIAL FEE UPON RECONSIDERATION REVIEW WITHOUT NOTICE AND AN OPPORTUNITY TO BE HEARD VIOLATES PLAINTIFFS' RIGHT TO PROCEDURAL DUE PROCESS OF LAW

272. Plaintiffs reallege and reincorporate the allegations contained in Paragraphs 1 - 271 herein.

273. The Commonwealth defendants, by maintaining a system which assesses a fee upon a "losing party" who may or may not have initiated the reconsideration review, and who has had no opportunity to be heard as to the merits of his claim, violates Plaintiffs' right to due process of law.

COUNT IV:

THE RECONSIDERATION FEE VIOLATES PLAINTIFFS' RIGHT TO SUBSTANTIVE DUE PROCESS OF LAW

274. Plaintiffs reallege and reincorporate the allegations contained in Paragraphs 1 - 273 herein.

275. The Commonwealth defendants, by maintaining a system which assesses a fee upon a "losing party" who may or may not have initiated the reconsideration review, who has had no opportunity to be heard as to the merits of his claim, and without regard to the claimants ability to pay, is arbitrary, irrational, and not in furtherance of any legitimate governmental purpose.

276. Accordingly, Commonwealth defendants' assessment of fees against claimants deemed to be losing parties in Reconsideration Review violates plaintiffs' right to substantive due process of law.

COUNT V:

THE LACK OF REGULATIONS GOVERNING PROCEEDINGS BEFORE WORKERS' COMPENSATION JUDGES REVIEWING URO DECISIONS VIOLATES PLAINTIFFS' RIGHT TO PROCEDURAL DUE PROCESS OF LAW

277. Plaintiffs reallege and reincorporate the allegations contained in Paragraphs 1 - 276 herein.

278. The Commonwealth defendants' failure to promulgate regulations governing the proceedings to be followed by Workers' Compensation Judges in the adjudication of Petitions for Review involving utilization review issues, creates disparate hearing procedures throughout the Commonwealth, and is arbitrary, irrational, and not in furtherance of any legitimate governmental purpose.

COUNT VI:

THE DEPRIVATION OF MEDICAL BENEFITS AUTHORIZED BY SECTIONS 306(f.l)(5) AND (6) DEPRIVE PLAINTIFFS OF LIBERTY WITHOUT DUE PROCESS OF LAW

279. Plaintiffs reallege and reincorporate by reference Paragraphs 1 - 278 above.

280. Defendants, acting under color of state law, have caused plaintiffs and the class they represent to be without the medical care necessary to reduce or eliminate their disabilities, and to alleviate pain and functional restriction.

281. The actions of the defendants were wanton, willful, and in reckless disregard of the plaintiffs' right to due process as articulated in Baksalary v. Smith.

282. As a result, defendants, acting pursuant to Section 306(f.1)(5) of the Pennsylvania Workers' Compensation Act, as amended, 77 P.S. § 531(5) (Supp. 1994), have unlawfully deprived plaintiffs and the members of the class they represent of liberty in violation of the Due Process Clause of the Fourteenth Amendment to the United States Constitution and 42 U.S.C § 1983.

VIII. PRAYER FOR RELIEF

WHEREFORE, plaintiffs respectfully pray that:

1. The Court enter an order declaring that this action be maintained as a class action pursuant to Rule 23(a) and (b)(2) of the Federal Rules of Civil Procedure.

2. The Court enter a judgment pursuant to 28 U.S.C. §§ 2201 and 2202 declaring Section 306(f.1)(5) of the Pennsylvania Workers' Compensation Act, as amended, 77 P.S. § 531(5) (Supp. 1994), and statewide practices developed thereunder, unconstitutional as violative of the due process clause of the Fourteenth Amendment to the United States Constitution and 42 U.S.C. § 1983.

3. The Court preliminarily and permanently enjoin the defendants, their successors in office or interest, and their agents, employees, and all other persons acting in concert with them, from withholding workers' compensation medical benefits to plaintiffs without first affording them prior notice and an opportunity for an evidentiary hearing at a meaningful time and meaningful manner.

4. The Court order the defendants, their successors in office or interest, and their agents, employees, and all persons acting in concert with them to immediately grant and/or restore to plaintiffs' medical compensation benefits which are presently being withheld or have been withheld at any time since the passage of Act 44 without prior notice or an opportunity for evidentiary hearing.

5. The Court order the named and class defendant insurance companies and self-insured employers and their

successors in interest to pay compensatory damages to the plaintiffs and each member of the class they represent for the automatic supersedeas of their medical benefits and all pain, suffering, emotional distress, and physical consequences resulting from the unilateral cessation of those benefits.

6. The Court order the named and class defendant insurance companies and self-insured employers to pay punitive damages for their wanton, willful, and reckless violation of the plaintiffs' due process rights.

7. The Court award plaintiffs all costs and reasonable attorneys fees incurred by them in the prosecution of this action.

Respectfully Submitted,

/s/LORRIE McKINLEY
LORRIE McKINLEY
SHARON GORNSTEIN

Community Legal Services, Inc.
1424 Chestnut Street, 5th Fl.
Philadelphia, PA 19102
(215) 981-3754

Counsel for Plaintiffs Delores Scott Sullivan, William Battle, Louis Baumgartner, Anthony Cancila, and Class Plaintiffs

ALAN EPSTEIN
Jablon, Epstein, Wolf, and Drucker
The Bellevue, Ninth Floor
Broad Street at Walnut
Philadelphia, PA 19102
(215) 790-0300

Counsel for William C. Dillon, Terrence Ervine, Charles Matthews, Christopher Costello, Lisa Lex, Susan Hansen, and Class Plaintiffs

THOMAS J. O'BRIEN
Galfand, Berger, Lurie, Brigham & March
1818 Market Street, 23rd Floor
Philadelphia, PA 19103
(215) 981-1600

Counsel for PhilaPOSH

LINDA MARTIN
RALPH TETI
Willig, Williams & Davidson
1845 Walnut Street, 24th Floor
Philadelphia, PA 19103

Counsel for Philadelphia Federation of Teachers

DATE: May 29, 1996

IN THE UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

[TITLE OMITTED IN PRINTING]

MOTION OF THE INSURER DEFENDANTS/ APPELLEES PURSUANT TO FED. R. APP. 41(B) TO STAY ISSUANCE OF MANDATE PENDING APPLICATION TO THE SUPREME COURT FOR WRIT OF CERTIORARI

[TEXT OF MOTION OMITTED IN PRINTING]

EXHIBIT A

[LOGO OMITTED IN PRINTING]

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF LABOR AND INDUSTRY
BUREAU OF WORKERS' COMPENSATION
1171 SOUTH CAMERON STREET; ROOM 103
HARRISBURG, PENNSYLVANIA 17104-2501
(717) 772-1914

DATE

NOTICE OF ASSIGNMENT OF UTILIZATION REVIEW REQUEST

NOTICE TO ALL PARTIES: This utilization review request has been made in accordance with the Workers' Compensation Act by the to determine the reasonableness or necessity of medical treatment provided or prescribed for the listed employe by the listed provider. It has been assigned to the Utilization Review Organization (URO) listed below:

URO: REVIEW#
NAME
ADDRESS

NOTICE TO EMPLOYE: If the determination of this Utilization Review is that your treatment under review is unreasonable or unnecessary it may result in these treatments not being paid. You can submit a written personal statement to the Utilization Review Organization shown on this Notice within 20 days of the date of this Notice regarding your view of the reasonableness and/or necessity of the disputed medical treatment. When you receive the Utilization Review determination, you can appeal the results in accordance with the instructions you receive on the Utilization Review Determination Face Sheet (LIBC-604).

EMPLOYEE: INJURY
SS#: DATE:
NAME
ADDRESS

NOTICE TO THE URO: You have five (5) days from receipt of this Notice to make a written request for records from the provider under review and all other treating providers listed on the Utilization Review request. You must complete your review and render your report within thirty (30) days of the date you receive the records or within sixty-five (65) days of the date of this Notice, whichever is earlier. If you have not received the records within thirty (30) days of the request, you may proceed with your review.

EMPLOYER:
NAME
ADDRESS

You have been assigned this case to render a determination only as to the reasonableness or necessity of the case under review. You may not give an opinion as to causation of the underlying injury or disease or the extent of the employe's disability under the Workers' Compensation Act. Also, do not render an opinion as to the reasonableness of a fee.

PROVIDER:
NAME
ADDRESS

You must return this request to the Bureau for reassignment within five (5) days of receipt of this Notice if you do not have the expertise or ability to render the review sought or if you have a conflict with rendering this review.

NOTICE TO EMPLOYER/ INSURER: You must pay the reasonable and customary charge of the URO for its services in connection with this Utilization Review. Payment must be made within thirty (30) days of the

date you receive the URO's determination.

INSURANCE
CARRIER:
NAME
ADDRESS

NOTICE TO HEALTH CARE PROVIDER: You must provide all necessary records to the URO within thirty (30) days of the date of its request. If you fail to do so, the URO may proceed with its review, resulting in a determination against your interest. You, or your agent, must verify that to the best of your knowledge, the medical records provided to the URO constitute the true and complete medical chart as it relates to the employe's work injury.

EMPLOYER/
INSURER
REPRESEN-
TATIVE:
NAME
ADDRESS

FRAUD INFORMATION: Any individual filing misleading or incomplete information knowingly and with intent to defraud is in violation of Section 1102 of the Pennsylvania Workers' Compensation Act and may also be subject to criminal and civil penalties through Pennsylvania Act 165 of 1994.

[LOGO OMITTED IN PRINTING]
COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF LABOR AND INDUSTRY
BUREAU OF WORKERS' COMPENSATION
1171 SOUTH CAMERON STREET; ROOM 103
HARRISBURG, PENNSYLVANIA 17104-2501
(717) 772-1914

DATE
REVIEW #:

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EMPLOYEE REPRESENTATIVE:
NAME
ADDRESS

NOTICE TO EMPLOYE: If the determination of this Utilization Review is that your treatment under review is unreasonable or unnecessary it may result in these treatments not being paid. You can submit a written personal statement to the Utilization Review Organization shown on this Notice within 20 days of the date of this Notice regarding your view of the reasonableness and/or necessity of the disputed medical treatment. When you receive the Utilization Review determination, you can appeal the results in accordance with the instructions you receive on the Utilization Review Determination Face Sheet (LIBC-604).

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to make a written request for records from the provider under review and all other treating providers listed on the Utilization Review request. You must complete your review and render your report within thirty (30) days of the date you receive the records or within sixty-five (65) days of the date of this Notice, whichever is earlier. If you have not received the records within thirty (30) days of the request, you may proceed with your review.

You have been assigned this case to render a determination only as to the reasonableness or necessity of the case under review. You may not give an opinion as to causation of the underlying injury or disease or the extent of the employe's disability under the Workers' Compensation Act. Also, do not render an opinion as to the reasonableness of a fee.

You must return this request to the Bureau for reassignment within five (5) days of receipt of this Notice if you do not have the expertise or ability to render the review sought or if you have a conflict with rendering this review.

NOTICE TO EMPLOYER/INSURER: You must pay the reasonable and customary charge of the URO for its services in connection with this Utilization Review. Payment must be made within thirty (30) days of the date you receive the URO's determination.

NOTICE TO HEALTH CARE PROVIDER: You must provide all necessary records to the URO within thirty (30) days of the date of its request. If you fail to do so, the URO may proceed with its review, resulting in a determination against your interest. You, or your agent, must verify that to the best of your knowledge, the medical records provided to the URO constitute the true and complete medical chart as it relates to the employe's work injury.

FRAUD INFORMATION: Any individual filing misleading or incomplete information knowingly and with intent to defraud is in violation of Section 1102 of the Pennsylvania Workers' Compensation Act and may also be subject to criminal and civil penalties through Pennsylvania Act 165 of 1994.

(8)

No. 97-2000

FILED
NOV 10 1998
OFFICE OF THE CLERK
SUPREME COURT, U.S.

In the Supreme Court of the United States

OCTOBER TERM, 1998

AMERICAN MANUFACTURERS MUTUAL INSURANCE COMPANY, ET AL., PETITIONERS

v.

DELORES SCOTT SULLIVAN, ET AL., RESPONDENTS

On Writ of Certiorari to the United States Court of Appeals for the Third Circuit

BRIEF FOR PETITIONERS

ROBERT MCL. BOOTE
BURT M. RUBLIN
Ballard Spahr Andrews & Ingersoll, LLP
1735 Market Street
Philadelphia, PA 19103
(215) 665-8500

Counsel for All Petitioners Except Donegal Mut. Ins. Co.

ROBERT E. KELLY, JR.
Duane, Morris, Heckscher LLP
305 N. Front Street
Harrisburg, PA 17108
(717) 237-5500

Counsel for Donegal Mut. Ins. Co.

MICHAEL W. MCCONNELL
Counsel of Record
ALAN E. UNTEREINER
STEFFEN N. JOHNSON
SHARON SWINGLE
Mayer, Brown & Platt
190 South La Salle Street
Chicago, IL 60603
(312) 782-0600

Counsel for All Petitioners

51 pp

QUESTIONS PRESENTED

Under Pennsylvania's Workers' Compensation Act, 77 Pa. Stat. Ann. § 531(5) and (6), workers' compensation insurers are permitted to withhold payments to health care providers during a utilization review to determine whether a particular medical treatment was reasonable and necessary. The questions presented are:

1. Whether private companies providing workers' compensation insurance to private employers become "state actors" for purposes of the Due Process Clause when they elect to use a state-authorized utilization review procedure.

2. Whether the Due Process Clause requires workers' compensation insurers to pay disputed medical bills prior to a determination that the medical treatment was reasonable and necessary.

RULE 24.1(b) AND 29.6 STATEMENT

Pursuant to Rule 24.1(b), petitioners state that in addition to American Manufacturers Mutual Insurance Company, petitioners here (also defendants in the court below) include Commercial Union Insurance Company, Continental Casualty Company, Donegal Mutual Insurance Company, Hartford Fire Insurance Company (misidentified in the Third Circuit caption as "Hartford Mutual Insurance Company"), Insurance Company of North America (misidentified in the Third Circuit caption as "CIGNA Corporation"), United States Fidelity and Guaranty Company (misidentified in the Third Circuit caption as "USF&G Insurance Company"), and Zurich Insurance Company (misidentified in the Third Circuit caption as "Zurich American Insurance Company").*

Defendants below who are respondents here are the School District of Philadelphia, the Pennsylvania Secretary of Labor and Industry, the Director of the Pennsylvania Bureau of Workers' Compensation, the Pennsylvania Insurance Commissioner, the Pennsylvania Treasurer, and the Director of the State Workers' Insurance Fund.

In addition to Delores Scott Sullivan, the individual plaintiffs in this putative class action include William Battle, Louis Baumgartner, Anthony Cancila, Christopher Costello, William C. Dillon, by his guardian and next friend Pauline Dillon, Terrence Ervine, Lisa Lex, Charles Matthews, and Susan Hansen. The organizational plaintiffs are the Philadelphia Area Project on Occupational Safety and Health and the Philadelphia Federation of Teachers. All of the plaintiffs below are respondents here.

Pursuant to Rule 29.6, a list of all parent companies and nonwholly owned subsidiaries of each of the corporate petitioners is contained in the Petition for a Writ of Certiorari at ii-iii. United States Fidelity and Guaranty Company has two additional non-wholly owned subsidiaries: JNO Industrial, Inc. and Octagon Services, L.L.C.

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* The parties stipulated below to a substitution of Insurance Company of North America for CIGNA Corporation.

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Cisneros v. *Alpine Ridge Grp.*, 508 U.S. 10 (1993) 34

Civil Rights Cases, 109 U.S. 3 (1883) 11, 12

Connecticut v. *Doehr*, 501 U.S. 1 (1991) 38, 47

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Davis v. *Mansfield Metro. Hous. Auth.*, 751 F.2d 180 (6th Cir. 1984) 34

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Estelle v. *Gamble*, 429 U.S. 97 (1976) 25

Eu v. *San Francisco County Democratic Cent. Comm.*, 489 U.S. 214 (1989) 12

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FDIC v. *Mallen*, 486 U.S. 230 (1988) 43

Flagg Brothers, Inc. v. *Brooks*, 436 U.S. 149 (1978) 15, 16, 18, 22

Fleming v. *Workers' Compensation Comm'n*, 1996 WL 93843 (4th Cir. Mar. 5, 1996), aff'g 878 F. Supp. 852 (E.D. Va. 1995) 17

George v. *Pacific-CSC Work Furlough*, 91 F.3d 1227 (9th Cir. 1996), cert. denied, 117 S. Ct. 746 (1997) 25

Georgia v. *McCollum*, 505 U.S. 42 (1992) 25

Gilbert v. *Homar*, 117 S. Ct. 1807 (1997) 38

Goldberg v. *Kelly*, 397 U.S. 254 (1970) . . . . . *passim*

Gregory v. *Town of Pittsfield*, 470 U.S. 1018 (1985) 37

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Lassiter v. *Department of Soc. Servs.*, 452 U.S. 18 (1981) . . . 38

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Rendell-Baker v. *Kohn*, 457 U.S. 830 (1982) . . . . . *passim*

Rust v. *Sullivan*, 500 U.S. 173 (1991) 12

Santosky v. *Kramer*, 455 U.S. 745 (1982) 38

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Schweiker v. *McClure*, 456 U.S. 188 (1982) 46

Shelley v. *Kramer*, 334 U.S. 1 (1948) 11, 16, 24

Silas v. *Smith*, 361 F. Supp. 1187 (E.D. Pa. 1973) 20

Smith v. *Allwright*, 321 U.S. 649 (1944) 18

Stanescu v. *Aetna Life & Cas. Ins. Co.*, 1996 WL 466648 (2d Cir. Aug. 16, 1996), cert. denied, 117 S. Ct. 1697 (1997) 17

Swann v. *Gastonia Hous. Auth.*, 502 F. Supp. 362 (W.D. N.C. 1980) 34

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United States Department of Labor v. *Triplett*, 494 U.S. 715 (1990) 45, 46

Walters v. *National Ass'n of Radiation Survivors*, 473 U.S. 305 (1985) 37, 45, 47

Washington v. *Glucksberg*, 117 S. Ct. 2258 (1997) . . . 47, 48, 50

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34 Pa. Code §127.404(b)-(d) 36

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34 Pa. Code §131.41 17
34 Pa. Code §131.43 17
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77 Pa. Stat. Ann. § 501(a)(1) 2
77 Pa. Stat. Ann. § 531 35
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77 Pa. Stat. Ann. § 1055 3
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Civil Rights Act of 1968, Pub. L. No. 90-284, 82 Stat. 81 (1968) 16

MISCELLANEOUS

D. BALLANTYNE & C. TELLES, WORKERS' COMPENSATION IN PENNSYLVANIA (1991) 2, 3
D. BALLANTYNE, REVISITING WORKERS' COMPENSATION IN PENNSYLVANIA (1997) 3, 40
Danzon, *Tort Liability: A Minefield for Managed Care?*, 26 J. LEGAL STUD. 491 (1997) 40
Dep't of Labor & Industry, *Workers' Compensation Medical Cost Containment*, PENNSYLVANIA BULLETIN 4875 (VOL. 25, NO. 45, NOV. 11, 1995) 43
S. ECCLESTON & C. YEAGER, WORKERS COMPENSATION RESEARCH INSTITUTE, MANAGED CARE AND MEDICAL COST CONTAINMENT IN WORKERS' COMPENSATION, A NATIONAL INVENTORY, 1997-1998 (1997) 31, 48, 49
Feldstein, *et al.*, *Private Cost Containment: The Effects of Utilization Review Programs on Health Care Use and Expenditures*, 318 NEW ENG. J. MED. 1310 (1988) . . . 39
Friendly, *Some Kind of Hearing*, 123 U. Pa. L. Rev. 1267 (1975) 45
Kelly & Kellie, *Appropriateness of Medical Care*, 114 ARCH. PATHOL. LAB. MED. 1119 (1990) 39
Leape, *Practice Guidelines and Standards: An Overview*, QUALITY REVIEW BULLETIN 42 (Feb. 1990) 39

J. LOCKE, SECOND TREATISE OF GOVERNMENT [1690] (T. Reardon, ed. 1952) 11

Marshall, *Diluting Constitutional Rights: Rethinking "Rethinking State Action,"* 80 NW. U. L. REV. 558 (1985) 13

PA. LEGIS. J. — HOUSE (Dec. 11, 1991) 40

PA. LEGIS. J. — SENATE (JUNE 16, 1993) 3

Schneider, *State Action — Making Sense Out of Chaos — An Historical Approach*, 37 U. FLA. L. REV. 737 (1985) 16, 19

Schwarzchild, *Value Pluralism and the Constitution: In Defense of the State Action Doctrine*, 1988 SUP. CT. REV. 129 13

Tracy, *The Importation of Managed Care to the Workers' Compensation System: Time for Re-evaluation and Re-direction*, 9 NO. 7 HEALTH LAW 16 (1997) 40

L. TRIBE, CONSTITUTIONAL CHOICES (1985) 24

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Walsh, *The Legal Attack on Cost Containment Mechanisms: The Expansion of Liability for Physicians and Managed Care Organizations*, 31 J. MARSHALL L. REV. 207 (1997) 40

Wickizer, *The Effect of Utilization Review on Hospital Use and Expenditures, in* REVIEW, REGULATE OR REFORM: WHAT WORKS TO CONTROL WORKERS' COMPENSATION COSTS 108 (1994) 39

A. WINDT, INSURANCE CLAIMS AND DISPUTES: REPRESENTATION OF INSURANCE COMPANIES AND INSUREDS (3d ed. 1995) 24

Letter from Timothy L. Wisecarver, President, Pennsylvania Compensation Rating Bureau, to Richard Himler, Director, Bureau of Workers' Compensation, Dept of Labor & Industry, Commonwealth of Pennsylvania (July 1, 1998), posted at <http://www.li.state.pa.us/wcletter.html> 43

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BRIEF FOR PETITIONERS

OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a-40a) is reported at 139 F.3d 158. The opinion of the district court dismissing the claims against the private insurers for lack of state action (Pet. App. 41a-61a) is reported at 913 F. Supp. 895. The district court's subsequent opinion dismissing the complaint and holding that the Pennsylvania statute does not violate procedural due process (Pet. App. 62a-82a) is unreported.

JURISDICTION

The judgment of the court of appeals was entered on March 13, 1998. The petition for a writ of certiorari was timely filed on June 11, 1998, and granted on September 29, 1998. This Court's jurisdiction rests on 28 U.S.C. § 1254(1).

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

The Fourteenth Amendment to the United States Constitution provides in relevant part that "[n]o State shall * * * deprive any person of life, liberty, or property, without due process of law." The pertinent provisions of the Pennsylvania Workers' Compensation Act (77 Pa. Stat. Ann. § 1 *et seq.*) and relevant regulations are set forth at Pet. App. 83a-103a.

STATEMENT

This case involves a constitutional challenge to actions of private insurance companies taken pursuant to Pennsylvania's workers' compensation law. Pennsylvania authorizes a workers' compensation insurer who believes that medical care provided to an injured worker may be unreasonable or unnecessary to obtain "utilization review" — an evaluation of the treatment by an independent medical professional — and to withhold payment to health care providers for the disputed care until review is completed. The Third Circuit held that when an insurance company initiates this procedure and withholds payment, it "become[s] an arm of the State," subject to the restrictions imposed by the Fourteenth Amendment. Pet. App. 15a. It also held that the private insurers violate the Due Process Clause by withholding payment pending the outcome of utilization review.

A. Pennsylvania's Workers' Compensation Statute And Its 1993 Cost-Containment Initiatives

Workers' compensation is a system under which employers are obligated to pay for medical care (and partial wage replacement) for employees who sustain work-related injuries or contract occupational diseases. Pet. App. 13a-14a; U.S. CHAMBER OF COMMERCE, 1997 ANALYSIS OF WORKERS' COMPENSATION LAWS, at vi. It is a no-fault substitute for the prior system of compensation under the common law of tort. See *Blake* v. *Wilson*, 112 A. 126, 128 (Pa. 1920).

The Pennsylvania workers' compensation system, involved here, is typical. Like most States, Pennsylvania makes workers' compensation coverage both mandatory and "exclusive * * * of any and all other liability." 77 Pa. Stat. Ann. § 481(a). The law dispenses with the prior cumbersome and expensive court remedy in tort and replaces it with an administrative procedure aimed at facilitating the prompt resolution of disputes between employers (or their insurers) and employees. The vast majority of claims are resolved through voluntary agreement. See D. BALLANTYNE & C. TELLES, WORKERS' COMPENSATION IN PENNSYLVANIA, at xix (1991). Disputes are adjudicated by workers' compensation judges, with a right of appeal to the Workers' Compensation Appeal Board ("Board") and then to the Pennsylvania courts. The Bureau of Workers' Compensation ("Bureau"), a part of the Department of Labor and Industry, administers the system and enforces compliance with workers' compensation laws.

To ensure that employers can meet their financial obligations, Pennsylvania requires them to "obtain insurance — either through a private insurance carrier or through the State Workmen's Insurance Fund," a state-conducted insurer — "or to self-insure." Pet. App. 3a. If the employer contracts with an insurer for coverage, the insurer "assume[s] the employer's liability" to pay workers' compensation benefits. 77 Pa. Stat. Ann. § 501(a)(1). Private insurers are not required to sell workers' compensation insurance and are free to decide which employers to underwrite. All features of workers' compensation insurance coverage that are not dictated by law are determined by contract. Moreover, "no

aspect of the workers' compensation system is financed with public tax dollars." D. BALLANTYNE & C. TELLES, *supra*, at 15.[1]

This case involves the procedures for resolving disputes over reimbursement of providers for medical care rendered to injured employees. The law requires insurers or self-insured employers[2] to pay only for "reasonable" and "necessary" medical care and services. 77 Pa. Stat. Ann. § 531(1), (5). Prior to 1993, however, insurers had no effective means to limit payments to such care. The "spiraling costs of medical treatment for work-related injuries" (Pet. App. 3a) became a "significant problem[] in the Pennsylvania system." D. BALLANTYNE & C. TELLES, *supra*, at 30. Between 1983 and 1991, workers' compensation medical costs increased by 240%. See D. BALLANTYNE, REVISITING WORKERS' COMPENSATION IN PENNSYLVANIA, at 67 (1997). By 1993, the State Workmen's Insurance Fund was on the verge of bankruptcy. PA. LEGIS. J. — SENATE 1044 (June 16, 1993) (statement of Sen. Fisher). Employers had just been subjected to a 24% rate increase in insurance premiums. *Id.* at 1048 (statement of Sen. Mellow). In an effort to control these costs, the Pennsylvania legislature passed Act 44, creating "a utilization review process under which the reasonableness and/or necessity of an employee's [current, prospective, or past] medical treatment could be reviewed." Pet. App. 3a.

Act 44 authorizes an insurer who receives a bill for medical care that it believes is unreasonable or unnecessary to obtain utilization review. 77 Pa. Stat. Ann. § 531(5). Insurers are permitted — though not required — to withhold payment for disputed medical bills during utilization review. *Ibid.* This is important because the law bars insurers from recouping payments

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[1] If a workers' compensation insurer in Pennsylvania becomes insolvent, its obligations are assumed by the Workers' Compensation Security Fund, 77 Pa. Stat. Ann. § 1053, but that fund is funded by taxes on the insurers themselves, *id.* § 1055. See also Pet. App. 14a n.18.

[2] Identical obligations are placed upon insurers and self-insured employers under this system. For simplicity's sake, we will usually refer in this brief simply to "insurers."

made to health care providers, even if the treatment is later determined to be unreasonable or unnecessary. Pet. App. 27a; see *Moats* v. *Workmen's Compensation Appeal Bd.*, 588 A.2d 116, 118 (Pa. Commw. Ct. 1991). Insurers and self-insured employers are entitled to reimbursement for excessive payments from a special fund, but the fund is financed entirely from assessments levied on the insurers and self-insured employers themselves. 77 Pa. Stat. Ann. § 999.

Under the Act, employees are permitted to go to the providers of their choice after the first 90 days of treatment for a job-related injury. 77 Pa. Stat. Ann. § 531(1)(i). Providers submit bills for treatment of the injured employee directly to the insurer. *Id.* § 531(5). An insurer has thirty days either to pay the bill or to file for utilization review, which tolls the payment deadline for disputed treatment. *Ibid.*; 34 Pa. Code §§ 127.208(e)-(f), 127.403. Utilization review is initiated by submitting to the Bureau an original and eight copies of a one-page form. 34 Pa. Code § 127.452(a); J.A. 5. The decision to obtain utilization review is made independently of the Bureau, which neither encourages nor discourages utilization review but "simply provides the forms" for initiating the process. C.A. App. B199-B200; see also Pet. App. 3a.

The Bureau conducts no substantive review of the form to determine whether utilization review is appropriate; requests are reviewed solely for facial adequacy. Pet. App. 5a. If the request is incomplete or facially defective, the Bureau rejects it and sends the requester a form letter identifying the basis for rejection. *Ibid.*; C.A. App. C23. If the request is complete and appears on its face to satisfy the formal criteria for utilization review, it is forwarded to a utilization review organization ("URO") selected randomly from a list of approved UROs. Pet. App. 6a; 34 Pa. Code § 127.453.

Next, the Bureau notifies the employee, the insurer, and the health care provider that a request for utilization review has been received and forwarded to the URO. Pet. App. 6a; 34 Pa. Code § 127.453. The current notice informs the employee that a determination that treatment is not reasonable or necessary "may result in these treatments not being paid." J.A. 50. The employee is also informed that he or she may "submit a written personal statement"

to the URO "regarding your view of the reasonableness and/or necessity of the disputed medical treatment." *Ibid.* Finally, the employee is informed of his or her right to seek administrative review of an adverse utilization review determination. *Ibid.*[3]

The URO is an independent, private entity that must be capable of performing "impartial reviews" of the medical reasonableness and necessity of disputed treatment. 34 Pa. Code § 127.663(b); Pet. App. 6a n.3. The URO's review must be conducted by a medical professional who is "licensed in the same profession and ha[s] the same or similar specialty as that of the provider of the treatment under review." 77 Pa. Stat. Ann. § 531(6)(i). The reviewer is required to give the provider an opportunity to discuss treatment decisions, and must initiate discussion with the provider if it will assist in determining whether disputed care was reasonable and necessary. 34 Pa. Code § 127.469. Utilization review applies "generally accepted treatment protocols" and a presumption that disputed treatment is reasonable and necessary. *Id.* §§ 127.467, 127.471(b). The reviewer must find treatment to be reasonable and necessary if the "provider's records document that [it] is relieving pain or allowing the patient to continue with the activities of daily living." C.A. App. B12.

Under the statute, the URO must issue a written decision within thirty days of a request, 77 Pa. Stat. Ann. § 531(6)(ii), though in practice this typically takes about seventy days. The URO's decision may be challenged by filing a petition with a workers' compensation judge, who conducts a *de novo* hearing at which the employee may submit testimony. Pet. App. 9a; 34 Pa. Code § 127.556. If the URO determines that a disputed medical service was reasonable and necessary, the insurer must pay the bill immediately with 10% annual interest, even if it petitions for review of the decision. 34 Pa. Code § 127.208(e), (g); 77 Pa. Stat. Ann. § 717.1(a). If the URO decides that the service was unreasonable or unnecessary, then the insurer need not pay the bill unless that decision is overturned by a workers' compensation judge, the Board, or the courts. The provider may not bill the

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[3] This form was revised to satisfy portions of the decision below that are not challenged by petitioners. See Pet. 22 n.12.

employee for treatment determined to be unreasonable or unnecessary. 34 Pa. Code § 127.211(b).

The statute includes within the definition of "medical services" not only "services rendered by physicians" but also the services of "any * * * physical therapist, psychologist, [or] chiropractor." 77 Pa. Stat. Ann. §§ 29 (defining "health care provider"), 531(1)(i), 531(3)(iii). Treatment by non-physician providers generates a disproportionate number of the disputes over the reasonableness and necessity of care.[4] Of the ten individual plaintiffs in this case, for example, one worker was receiving twice-weekly chiropractic sessions more than six years after his injury (J.A. 28); one was undergoing "aquatic therapy" (*id.* at 30); one was still receiving chiropractic services and physical therapy more than fifteen years after his injury, and nearly twelve years after he had returned to work (and who was running his own business) (*id.* at 35-36); and one was receiving psychological and biofeedback therapy (*id.* at 42). The Third Circuit stated that procedural safeguards are "particularly" pertinent to recipients "of unorthodox, naturopathic, or non-traditional" treatments "such as * * * acupuncture or chiropractic manipulation." Pet. App. 31a.

B. Proceedings In The District Court

Plaintiffs in this putative class action (respondents here) are ten individuals who were or are employed in Pennsylvania and two organizations that represent Pennsylvania employees. Pet. App. 9a & nn.7-8.[5] The private defendants (petitioners here) are American

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[4] For example, approximately 37% of requests for utilization review involve care provided by chiropractors, while only 17% involve care provided by family doctors or general practitioners. Letter from Timothy L. Wisecarver, President, Pennsylvania Compensation Rating Bureau, to Richard Himler, Director, Bureau of Workers' Compensation, Dep't of Labor & Industry, Commonwealth of Pennsylvania (Oct. 29, 1998), posted at <http://www.li.state.pa.us/wcletter.html>.

[5] The proposed plaintiff class "consists of more than 40,000 workers' compensation recipients" who "have been, or will be in the future, receiving medical benefits pursuant to the Pennsylvania Worker's Compensation [Act]" and whose benefits have been or will be suspended during utilization review. J.A. 12-13, 16.

Manufacturers Mutual Insurance Company and seven other private insurance companies that write workers' compensation policies in Pennsylvania. Plaintiffs also named as defendants the School District of Philadelphia and various state officials, who are also respondents here.[6] Plaintiffs' amended complaint requested that the court certify a defendant class of all insurance companies and self-insuring employers that have invoked the Pennsylvania utilization review procedure and withheld reimbursement for medical care during the pendency of that review. J.A. 16.

Plaintiffs alleged that Act 44's utilization review procedures violate due process and 42 U.S.C. § 1983 because they permit the deprivation of "medical benefits" without "advance notice and prior opportunity to be seen and heard * * *." J.A. 43. They sought declaratory and injunctive relief, restoration of benefits, and compensatory as well as punitive damages.

The insurers moved to dismiss on the ground that, as private companies, they are not state actors and thus cannot be sued for violations of the Due Process Clause or for action under color of state law (42 U.S.C. § 1983). After limited discovery, the district court granted their motion. Pet. App. 41a-61a. It explained that the government's involvement in the private insurers' decision to invoke utilization review and withhold payment was minimal. *Id.* at 59a. The State did not promote, support, or encourage the decision of an insurer to obtain utilization review of disputed treatment in a particular case, and the State took no action to influence a utilization reviewer's determination whether disputed treatment was medically reasonable and necessary. *Ibid.* Rather, the State merely provided private actors with a remedy for unwarranted medical claims. *Ibid.*

The state officials who remained as defendants subsequently moved to dismiss on the ground that the Pennsylvania statute does

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[6] For a complete list of parties, see page ii, *supra*. On October 5, 1998, this Court denied petitions for certiorari filed by the School District of Philadelphia (No. 97-2030) and various officials of the Commonwealth of Pennsylvania (No. 98-161).

not violate procedural due process. The district court granted that motion, Pet. App. 62a-81a, after evaluating the process provided by the statute under the balancing test set forth in *Mathews* v. *Eldridge*, 424 U.S. 319, 335 (1976). The court concluded that while an injured employee's interest in continued receipt of medical benefits was "significant" (Pet. App. 70a), it was less substantial than the interest at stake in *Goldberg* v. *Kelly*, 397 U.S. 254 (1970), because eligibility is "not based on financial need," and because the employee "may have access to additional income sources such as wage replacement." Pet. App. 70a. In addition, the court noted, the availability of full retroactive relief — as well as 10% interest to the provider and litigation costs to the worker — "lessens the potential harm to the individual employees." *Ibid.* The court observed that "nothing in the statute even requires that the medical provider stop giving the challenged treatment." *Id.* at 70a n.4. It also took note of the government interest in controlling the "high costs of medical treatment, and the corresponding high cost of insurance" in Pennsylvania. *Id.* at 75a. Balancing all of these considerations, the district court concluded that the Pennsylvania law does not violate due process.

C. Proceedings In The Court Of Appeals

A panel of the Third Circuit reversed the district court's rulings on both state action and due process issues. Pet. App. 1a-40a. In holding that the private insurers are state actors, the court of appeals emphasized that the workers' compensation system is mandatory in nature, abolishes the common law rights of employers and employees, and provides "the *exclusive* remedy available to an injured worker" in Pennsylvania. *Id.* at 13a-14a. The court also stressed that, "[i]n creating and executing this system of entitlements, the Commonwealth has enacted a complex and interwoven regulatory web enlisting the Bureau, the employers, and the insurance companies." *Id.* at 14a. Pennsylvania

> extensively regulates and controls the Workers' Compensation system. Although the insurance companies are private entities, when they act under the construct of the Workers' Compensation system, they are providing public benefits which honor State entitlements. In effect, they become an arm of the State,

> fulfilling a uniquely governmental obligation under an entirely state-created, self-contained public benefit system.

Id. at 14-15a. The Pennsylvania law thus creates a "relationship" between the State and the insurer that "more than suffices to satisfy the constitutional requisites under the tests — varied though they may be — for state action." *Id.* at 19a.

Turning to the due process issue, the Third Circuit held that the notice provided to employees that payments might be withheld from medical providers was constitutionally deficient and that due process requires that individual patients be given an opportunity to submit their written views on the reasonableness and necessity of challenged care to the utilization reviewer. Pet. App. 21a-33a. Petitioners have not challenged those holdings in this Court. See Pet. 22 n.12. The Third Circuit also evaluated whether payments for disputed medical services could be withheld pending utilization review, a question it characterized as whether employees were entitled to "a pre-deprivation opportunity to respond to the proposed termination of their medical benefits" under the *Mathews* balancing test. Pet. App. 25a.

The Third Circuit acknowledged that Pennsylvania has a legitimate interest in "containing the rising costs of medical care and insurance payments," and observed that "cost containment is the purpose" behind the State's enactment of the law authorizing insurers to withhold payments to medical providers during utilization review. Pet. App. 29a-30a. It rejected the district court's conclusion, however, that the risk of erroneous deprivation was slight because utilization review involved the narrow question of medical reasonableness or necessity, decided solely on the basis of "unbiased, objective, and trustworthy" medical records. *Id.* at 28a. It also rejected the contention that in applying the *Mathews* test it was required to "consider the conflicting private interest of the insurance companies." *Id.* at 27a. "On balance," the court explained, "we are not convinced that any governmental interest outweighs the [employees'] private interest" in uninterrupted payment of providers. *Id.* at 30a. The employee's interest could be adequately protected, the court held, only if insurers were required to pay the disputed bills until workers are given "an opportunity and time to submit a personal statement in writing" to

the utilization review organization "regarding the employee's view of the reasonableness and/or necessity of the disputed medical treatments." *Id.* at 33a.

Accordingly, the Third Circuit declared unconstitutional the statutory provision permitting suspension of payment, which provides:

> All payments to providers for treatment provided pursuant to this act shall be made within thirty (30) days of receipt of such bills and records *unless the employer or insurer disputes the reasonableness or necessity of the treatment provided pursuant to paragraph (6)* * * *.

77 Pa. Stat. Ann. § 531(5) (emphasis added). Pet. App. 24a. The court reasoned that the italicized language — the provision it deemed offensive — was severable, and struck it from the statute. *Id.* at 25a. Under the Third Circuit's holding, therefore, the statute requires an insurer to pay provider bills within thirty days of receipt even if it seeks utilization review of the treatment.

INTRODUCTION AND SUMMARY OF ARGUMENT

The question in this case is whether the Due Process Clause is violated when private workers' compensation insurers, acting solely on their own business judgment, delay payment of disputed claims during the approximately two-month period it takes to determine whether the claims are valid. Such decisions take place in the thousands every month, in the context of almost every kind of insurance. Indeed, analogous decisions — to delay payment of a disputed contractual obligation until the dispute has been settled — are commonplace in *every* kind of business.

Under the decision below, these routine business judgments have been declared to "satisfy the constitutional requisites" for "state action." Pet. App. 19a. The practical consequence of this holding is to allow a federal court to cast aside Pennsylvania's carefully considered legislative reforms of workers' compensation law and to substitute its own notions of how to balance the risks between insurers and health care providers. Equally remarkably, the court of appeals held that delaying the payment of a doctor's bill deprives the patient of due process of law. The practical consequence of that holding is to require insurers to pay medical

claims before they can be examined for possible fraud and abuse. That is a recipe for disaster in the health care financing system.

We will demonstrate below that both aspects of the Third Circuit's decision are in error. In Part I, we will show that the unilateral business decisions of private insurance companies do not constitute "state action" under any coherent theory, and that the contrary holding below is a product of a loose and undisciplined approach that is squarely at odds with at least three of this Court's decisions. In Part II, we will show that the individual plaintiffs have not suffered any "deprivation" sufficient to support the due process holding, and that even if they had, the procedures here are fully adequate to satisfy due process.

ARGUMENT

I. PRIVATE INSURANCE COMPANIES DO NOT BECOME STATE ACTORS BY INITIATING UTILIZATION REVIEW OR WITHHOLDING PAYMENTS TO HEALTH CARE PROVIDERS

The very language of the Fourteenth Amendment — "[n]o State shall * * * deprive any person of life, liberty, or property without due process of law" — bespeaks its applicability to governmental bodies and not to private persons. Consistent with this language, this Court has always maintained, ever since the issue first arose in the *Civil Rights Cases*, 109 U.S. 3 (1883), that "'the action inhibited by the first section of the Fourteenth Amendment is only such action as may fairly be said to be that of the States.'" *Blum* v. *Yaretsky*, 457 U.S. 991, 1002 (1982) (quoting *Shelley* v. *Kramer*, 334 U.S. 1, 13 (1948)). In short, the Fourteenth Amendment "erects no shield against merely private conduct." *Shelley*, 334 U.S. at 13.

In all state action cases, the question posed is whether constitutional norms designed to limit governmental power are applicable to an arguably nongovernmental party. This distinction between public and private lies at the very heart of liberal theory. See generally J. LOCKE, SECOND TREATISE OF GOVERNMENT 44-73 [1690] (T. Reardon, ed. 1952). More specifically, the state action doctrine serves three important functions. First, in some contexts, the state action doctrine protects the federal structure of government

by limiting the scope of federal authority to its proper role in enforcing constitutional provisions directed at the States. See *Civil Rights Cases*, 109 U.S. 3 (1883).

Second, in some contexts, the state action doctrine is a recognition of the fact that many constitutional norms are liberty-enhancing when applied to the government yet liberty-infringing when applied to private parties. Compare *Hurley* v. *Irish-American Gay, Lesbian and Bisexual Group*, 515 U.S. 557, 572-73 (1995) (because parade organizers were private parties, the obligation of speech neutrality that would otherwise have attached to a public parade had to yield to free speech rights of organizers), with *Rust* v. *Sullivan*, 500 U.S. 173, 193-94 (1991) (free speech claim rejected because the speakers were, in effect, communicating the government's own message and not their own). See also *Corporation of Presiding Bishop of Church of Jesus Christ of Latter-Day Saints* v. *Amos*, 483 U.S. 327, 339 (1987) (application of religious nondiscrimination requirement to a religious body would interfere with religious freedom); *Eu* v. *San Francisco County Democratic Cent. Comm.*, 489 U.S. 214, 224-25 (1989) (application of political neutrality requirements to political party would interfere with political advocacy). Procedural due process norms — those at issue here — make sense as applied to the government but would be highly disruptive if applied to a family or a business.

Third — and most directly pertinent here — the state action doctrine polices the boundary between judicial and legislative authority. See *Lugar* v. *Edmondson Oil Co.*, 457 U.S. 922, 936-37 (1982). Because constitutional norms (applicable to the government) are directly enforceable by the judiciary, a finding of "state action" has the effect of transferring regulatory authority from the legislature to the courts. Where the constitutional principle is procedural due process and the supposed "state actors" are insurance companies, a finding of state action renders any aspect of their business that can be characterized as "procedural" in nature (which is much, since processing claims is at the heart of the business) subject to judicial review — and the regulatory framework established by statute becomes vulnerable to judicial second-guessing.

In this case, for example, the effect of the "state action" holding was to empower a panel of federal appellate judges to second-guess the details of Pennsylvania's statutory scheme for regulation of the workers' compensation insurance business, and to overturn the balance the legislature struck between workers, health care providers, employers, and insurers. For reasons made manifest in the experience of this Court with economic substantive due process (see *Lochner* v. *New York*, 198 U.S. 45 (1905)), such transfers of authority from legislatures to courts are inconsistent with the democratic spirit of our institutions, and frequently result in bad policy as well. Not only are federal judges ill-equipped to make informed judgments about the insurance business (and others), but stare decisis makes constitutional litigation an inflexible and dangerous tool for routine regulatory decisionmaking. Constitutional rulings must be relatively fixed, and are not easily changed or corrected in response to experience. Decisions such as who should bear the risk of error when a provider is suspected of giving unnecessary or unreasonable care require an exercise of policy judgment on the basis of empirical experience, and should not be set in constitutional concrete. For this reason, it is vitally important that the limits of state action doctrine be observed, lest broad areas of economic and social activity be placed under the superintendence of constitutional courts rather than accountable legislatures. See Marshall, *Diluting Constitutional Rights: Rethinking "Rethinking State Action,"* 80 NW. U. L. REV. 558 (1985); Schwarzchild, *Value Pluralism and the Constitution: In Defense of the State Action Doctrine*, 1988 SUP. CT. REV. 129.

Unfortunately, the line between state and private action is not always easy to draw. This Court's decisions mandate careful and rigorous attention to the factual and legal context. The Third Circuit itself complained that courts faced with state action issues "have employed various tests and standards that have been anything but a model of clarity." Pet App. 13a. Having recognized the problem, however, the Third Circuit essentially threw up its hands, resorting to a undisciplined mode of analysis that opens the door to a dangerous expansion of state action doctrine.

A. A Private Insurer's Decision To Initiate Utilization Review Or To Withhold Payments To Health Care Providers Does Not Transform The Insurer Into An Arm Of The State

The analytical framework for deciding when the conduct of a private entity "allegedly causing the deprivation of a federal right [is] fairly attributable to the State" is set out in *Lugar* v. *Edmondson Oil Co.*, 457 U.S. 922, 937 (1982):

> First, the deprivation must be caused by the exercise of some right or privilege created by the State or by a rule of conduct imposed by the State or by a person for whom the State is responsible. * * * Second, the party charged with the deprivation must be a person who may fairly be said to be a state actor.

The first factor under *Lugar* serves to exclude cases where the private entity acts in violation of state law. *Id.* at 940. The second *Lugar* factor measures the "something more" — beyond mere state authorization — that is required in order for the conduct of private entities to be transformed into state action. *Id.* at 937, 939. This "something more," which the Court has "articulated [in] a number of different factors or tests in different contexts," is critically important because it ensures that "private parties" do not "face constitutional litigation whenever they seek to rely on some state rule governing their interactions with the community surrounding them." *Ibid.* These "factors or tests" are thus the heart of the state action analysis.

In marked contrast to the rigorous analysis this Court has used in its state action decisions, the Third Circuit offered a vague set of truths, half-truths, and irrelevancies in support of its conclusion that private companies making decisions pursuant to private contracts of insurance with private employers are "state actors." The appellate court stated that Pennsylvania's workers' compensation system is "a complex and interwoven regulatory web" (Pet. App. 14a), and a "'system which the government alone administers'" (*id.* at 15a (quoting *Edmonson* v. *Leesville Concrete Co*, 500 U.S. 614, 622 (1991))); that the system is "mandatory" and "exclusive," thus assertedly making workers' compensation payments a "public benefit[]" (*id.* at 14a-15a); and that the "right

to invoke the supersedeas, or to stop payments, is a power that traditionally was held in the hands of the State" (*id.* at 15a).

Under no coherent theory of state action could these miscellaneous factors lead to the conclusion that an insurer who temporarily withholds payments from health care providers or initiates the process of utilization review "may fairly be said to be a state actor." *Lugar*, 457 U.S. at 937. Unfortunately, the Third Circuit did not think it necessary to offer a coherent theory. Having cited these various factors, the court simply concluded that this "relationship more than suffices to satisfy the constitutional requisites under the tests — varied though they may be — for state action." Pet. App. 19a. It then emphasized that its holding is "expressly limit[ed]" to the "unique context" of this case, *ibid.*, as if that could substitute for a clear explanation of why the facts of this case fit within established principles of state action doctrine.

Contrary to the Third Circuit's suggestion, this Court's cases delineating what is required (beyond state authorization of private conduct) for the conduct of private entities to be regarded as state action in fact fall into defined doctrinal categories with distinct and different definitions. See *Flagg Brothers, Inc.* v. *Brooks*, 436 U.S. 149, 158, 159 (1978) (examining in turn various discrete "line[s] of cases" and noting that the scope of the Court's "exclusive public function" cases involving elections is "carefully defined"). The definitions of state action under each category are not mere ingredients to be thrown together in a doctrinal stew, with a pinch of salt substituting for a lack of garlic or coriander. The Third Circuit's decision dramatically relaxes the requirements needed to find state action by authorizing federal judges to "mix and match" factors from various doctrinal categories that would not suffice, individually, to show state action under any of those categories. This Court should reject the Third Circuit's eclectic approach and reaffirm the distinctive and separate nature of its "public function," "state compulsion," and "joint action" cases. Cf. *Lugar*, 457 U.S. at 939 (declining to resolve whether these tests are "actually

different in operation or simply different ways of characterizing" the state action inquiry).[7]

As we explain below, the conduct of private insurance companies that is challenged in this lawsuit — withholding payments to health care providers and initiating utilization review

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[7] Between the 1940s and late 1960s, this Court significantly expanded the state action doctrine in a series of cases, many of which involved claims of racial discrimination. See, *e.g.*, *Shelley* v. *Kramer*, 334 U.S. 1 (1948) (state action exists when state court enforces racially restrictive covenants); *Marsh* v. *Alabama*, 326 U.S. 501 (1946) (arrest by policeman in company-owned town constitutes state action); *Burton* v. *Wilmington Parking Auth.*, 365 U.S. 715, 725 (1961) (restaurant's refusal to serve black customer constituted state action where the state had "so far insinuated itself into a position of interdependence with" the restaurant that they "must be recognized as joint participant[s] in the challenged activity"). As one commentator has observed, the "need to expand the state action doctrine" during 1940-1970 was the result, in part, of the "absence of means other than the fourteenth amendment to attack racial injustice." Schneider, *State Action — Making Sense Out of Chaos — An Historical Approach*, 37 U. FLA. L. REV. 737, 741 (1985). In the 1960s, however, Congress passed a variety of civil rights statutes prohibiting racial discrimination in employment, education, public accommodations, housing, and other areas, making an expansive state action doctrine unnecessary. See, *e.g.*, Civil Rights Act of 1964, Pub. L. No. 88-352, 78 Stat. 241 (1964); Civil Rights Act of 1968, Pub. L. No. 90-284, 82 Stat. 81 (1968).

Beginning in the early 1970s, this Court returned to a more restrictive approach to state action, which has continued to this day. For example, the Court overruled a decision that had extended the rule of *Marsh* v. *Alabama*, 326 U.S. 501 (1946), to a privately owned shopping center. See *Flagg Brothers*, 436 U.S. at 159-60. Compare *Hudgens* v. *NLRB*, 424 U.S. 507, 514-21 (1976), with *Amalgamated Food Employees Union Local 590* v. *Logan Valley Plaza*, 391 U.S. 308, 316-20 (1968). And in *Jackson* v. *Metropolitan Edison Co.*, the Court made clear that its "public function" theory of state action was limited to those situations where a private entity exercises powers that are "traditionally *exclusively* reserved to the State." 419 U.S. 345, 352 (1974) (emphasis added); see also *Rendell-Baker* v. *Kohn*, 457 U.S. 830, 842 (1982). The decision below is in a sense a throwback to an earlier era, but without the pressing justification that underlay this Court's decisions during that time.

— does not qualify as "state action" under any of this Court's established categories of state action. The decision to initiate utilization review and to withhold reimbursement is hardly a "public function" that traditionally has been reserved exclusively to the State; it is in no way compelled by Pennsylvania; and the State's "participation" does not amount to the provision of "such significant encouragement, either overt or covert, that the [insurer's] choice must in law be deemed to be that of the State." *Blum* v. *Yaretsky*, 457 U.S. 991, 1004 (1982). Nor has the State delegated to insurers any constitutional duty to perform. Not surprisingly, every federal court of appeals to consider the issue, other than the court below, has concluded that workers' compensation insurers making decisions of this sort are not state actors. *Stanescu* v. *Aetna Life & Cas. Ins. Co.*, 1996 WL 466648 (2d Cir. Aug. 16, 1996), cert. denied, 117 S. Ct. 1697 (1997); *Fleming* v. *Workers' Compensation Comm'n*, 1996 WL 93843 (4th Cir. Mar. 5, 1996) (per curiam), aff'g 878 F. Supp. 852 (E.D. Va. 1995); *Grenz* v. *EBI/Orion Group, Inc.*, 1992 WL 158158 (9th Cir. July 9, 1992); *Barnes* v. *Lehman*, 861 F.2d 1383 (5th Cir. 1988); see also *Henderson* v. *Workmen's Compensation Appeal Bd.*, 452 A.2d 277, 278-80 (Pa. Commw. Ct. 1982). The Third Circuit was thus wrong to conclude that there was state action in this case.

1. The Private Insurers Are Not Performing An Exclusive Public Function

In analyzing the state action issue, the Third Circuit declared, without citation to state law or other authority, that "[t]he right to invoke the supersedeas, or to stop payments, is a power that traditionally was held in the hands of the State." Pet. App. 15a.[8]

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[8] The Third Circuit repeatedly but erroneously used the term "supersedeas" to denote the company's decision to delay payment of a disputed claim (Pet. App. 15a; see also *id.* at 2a, 13a). This term is not used in the relevant statutory provision, 77 Pa. Stat. Ann. § 531(5). Under Pennsylvania law, the term "supersedeas" is used to refer to an order by a workers' compensation judge suspending the obligation to pay an award. See, *e.g.*, 77 Pa. Stat. Ann. §§ 774, 971(b); 34 Pa. Code §§ 131.41, 131.43. But no such order is needed when an insurer initiates utilization review under Section 531(5), nor is any judge involved at this stage. Instead, Section 531(5) merely sets a 30-day deadline in which the

The court of appeals also characterized the provision of workers' compensation benefits as a "uniquely governmental obligation." *Ibid.* To the extent that it was suggesting that the private insurance companies qualify as state actors because they perform an exclusive public function, the Third Circuit seriously misapprehended the scope of the "public function" doctrine.

In *Jackson* v. *Metropolitan Edison Co.*, this Court made clear that the "public function" doctrine applies *only* when a private entity exercises powers that have been "traditionally *exclusively reserved* to the State." 419 U.S. 345, 352 (1974) (emphasis added); accord *Rendell-Baker* v. *Kohn*, 457 U.S. 830, 842 (1982); *Flagg Brothers*, 436 U.S. at 157-58. Examples include the conduct of elections, see *Smith* v. *Allwright*, 321 U.S. 649 (1944), the selection of juries, see *Leesville Concrete*, 500 U.S. 614, the management of municipal parks, see *Evans* v. *Newton*, 382 U.S. 296 (1966), and the power of eminent domain, see *Jackson*, 419 U.S. at 353.

Neither the provision of workers' compensation benefits in general nor the decision to delay payment of questionable bills in a particular case is typically a governmental function at all — let alone an "exclusive" governmental function. As explained above (at 2), workers' compensation systems are simply a substitute for the tort system — different procedures and rules for determining the employer's liability to its workers for workplace injuries. To be sure, the underlying workers' compensation liability of the employer, which is the subject of the insurance, is imposed by the State. That fact, however, does not render the State responsible for the payment, or the insurer an arm of the State. Tort liability is also imposed by state law, but that does not make tort liability insurers state actors. Valid tort claims would have an equal claim

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insurer must pay for medical expenses, but then tolls the deadline if the insurer elects to initiate utilization review. There is no "supersedeas."

to be described as "protected entitlements," yet no one would say that insurance payments to a tort victim are "public benefits."[9]

It is no answer to say, as did the Third Circuit, that private insurance companies are carrying out an exclusive public function because workers' compensation benefits are a "uniquely governmental obligation." Pet. App. 15a. The premise of that argument is erroneous: Pennsylvania does not have any obligation to provide workers' compensation benefits itself; rather, it imposes that obligation on private parties. No taxes or legislative appropriations are involved; the entire system is financed through premiums paid by private employers. See *Dillard* v. *Industrial Comm'n*, 416 U.S. 783, 798 (1974) (workers' compensation funds "are private, not public"). Contrary to the Third Circuit's suggestion, the workers' compensation system is more accurately viewed as a mandatory term of the private employment contract between employer and employee, not unlike the minimum wage. An employer's unilateral decision to reduce a worker's wages to $1 per hour might be a violation of the minimum wage law, or of the labor contract, but it would not be a violation of constitutional due process. In any event, this Court rejected a virtually identical argument in *Jackson*. There, the utility customer argued that the electric company was providing an "essential public service required to be supplied" and thus was performing a public function. 419 U.S. at 352. This Court responded that "while the Pennsylvania statute imposes an obligation to furnish service *on regulated utilities*, it imposes no such obligation *on the State*." *Id.* at 353 (emphasis added).

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[9] The Third Circuit also stated, somewhat ambiguously, that workers' compensation benefits are a "constitutionally protected entitlement." Pet. App. 14a. The right to receive workers' compensation benefits is *not* conferred by the federal or Pennsylvania constitution, but rather by Pennsylvania statute. If the Third Circuit meant merely to say that workers' compensation benefits represent a "property interest" subject to some due process protection, that statement puts the cart before the horse (appearing, as it does, in the Third Circuit's threshold discussion of state action). Whether the Constitution confers *any* protection on workers vis-a-vis the actions of private insurers hinges on whether those insurers qualify as state actors; the Third Circuit's reliance on this factor was thus entirely circular.

Nor is the withholding of payments to a health care provider for medical care an exclusive public function. It is a routine aspect of claims processing for insurance carriers of all kinds. Indeed, it is a remarkable notion, to say the least, that a private insurance company's withholding of payments to a private party (the health care provider) under a contract with another private entity (the employer) pending resolution of a dispute over the entitlement of a private, third-party beneficiary under the contract (the employee) amounts to a traditional public function. Petitioners, after all, are private companies that have voluntarily entered into private contracts of insurance with private employers. As one court has explained:

> What is here involved is a contractual (although sanctioned by statute) claim to benefits which the other party to the contract disputes. As such, this interest is indistinguishable from the interest of the recipient of funds in any commercial situation in which periodic payments are terminated pending resolution of the underlying dispute.

Silas v. *Smith*, 361 F. Supp. 1187, 1192 (E.D. Pa. 1973) (three-judge court).

2. The Private Insurers Are Not Acting Under State Compulsion

In a separate line of cases, this Court has made clear that "a State is responsible for the discriminatory act of a private party when the State, by its law, has compelled the act." *Adickes* v. *S.H. Kress & Co.*, 398 U.S. 144, 170 (1970); see also *Peterson* v. *City of Greenville*, 373 U.S. 244, 248 (1963) ("When the State has commanded a particular result, it has saved to itself the power to determine that result and thereby 'to a significant extent' has 'become involved' in it."). This "state compulsion" test (*Lugar*, 457 U.S. at 939) cannot possibly be satisfied here.

As the district court explicitly found, the decision to withhold payment of disputed medical bills is made entirely by the insurers, with no hint of coercion by the State. Pet. App. 59a. Even the court of appeals acknowledged that "[t]he Act does not require — but permits — suspension of medical benefits." *Id.* at 5a. Similarly, the State in no way compels petitioners to initiate the

utilization review process. See *id.* at 3a ("The decision to invoke utilization review is made independently by the employer or insurer."). Indeed, the Commonwealth does not even *encourage* insurers to withhold payment or initiate utilization review in any particular case. See *id.* at 59a (the State "takes no substantive step to promote, support or encourage the decision of the insurer" to withhold payments). On the contrary, Pennsylvania law requires the insurer to pay for the cost of utilization review regardless of its outcome. *Id.* at 8a; 77 Pa. Stat. Ann. § 531(6)(iii). In addition, if the URO determines that the disputed medical care was reasonable and necessary, the insurer must not only pay the bill immediately but must also pay 10% annual interest on the amount withheld. 34 Pa. Code. § 127.208(e), (g); 77 Pa. Stat. Ann. § 717.1(a). In light of these disincentives, the statute cannot be said to "encourage" insurers to invoke utilization review — any more than the availability of *any* state-created remedy "encourages" resort to the remedy to gain relief.

Even if the State's workers' compensation scheme did encourage insurers to withhold payments to health care providers and to initiate utilization review, moreover, that would not suffice to convert the insurers' choices into the choices of the State. In *Blum* v. *Yaretsky*, 457 U.S. 991 (1982), this Court refused to find state action in the choice of a private entity pursuant to a statutory authorization that encouraged the authorized actions. See *Rendell-Baker*, 457 U.S. at 841 (noting that "[b]oth [the] state and federal regulations" in *Blum* "encouraged the nursing homes to transfer patients to less expensive facilities when appropriate"). Because the private insurers' choices are entirely free from state compulsion, there is no state action under this line of authority.[10]

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[10] The Third Circuit appeared to attach significance to the fact that workers and employers are required to participate in the workers' compensation system in Pennsylvania. See Pet. App. 14a, 16a, 18a. But even if the State compels participation, that does not mean that the specific actions of the insurers at issue in this case are compelled. Students are compelled to go to school, but that doesn't make their conduct at school state action. In any event, it is only the employers and employees, not the insurers, who are compelled to participate in the system.

Thus, there is neither compulsion nor encouragement in this case. There is instead only State *authorization* — enough, in other words, to satisfy the first *Lugar* factor, but not the second. As this Court has repeatedly held, the "[p]rivate use of state-sanctioned remedies or procedures does not rise to the level of state action." *Tulsa Professional Collection Servs., Inc.* v. *Pope*, 485 U.S. 478, 485 (1988); see also *Flagg Brothers*, 436 U.S. at 161 n.11, 164. That principle is controlling here.

3. Pennsylvania's Ministerial Role In The Utilization Review Process Does Not Place The State's "Imprimatur" On The Private Insurers' Conduct Nor Does It Make The State A Joint Participant With The Insurers

In finding state action, the Third Circuit also relied on the fact that an insurer seeking utilization review must first file a one-page form with the Bureau of Workers' Compensation, which will be disapproved if it fails to include all of the required information. According to the court of appeals, this means that "[t]he insurers have no power to deprive or terminate such benefits without the permission and participation of the Commonwealth" (Pet. App. 15a) and that "the Commonwealth is intimately involved in any decision by an insurer to * * * suspend medical payments." *Ibid.* This argument rests on a mischaracterization of the Bureau's role as well as a mistaken view of what is required to convert private conduct into state action under this Court's "joint action" cases.

Contrary to the Third Circuit's apparent view, the requirement of filing a form is an inconsequential detail in the regulatory scheme. The Bureau's role in processing the form (including forwarding the form, if properly completed, to a randomly selected URO) is purely ministerial.[11] As the Third Circuit itself stated, the

[11] When the Bureau receives a request for utilization review, Bureau staff check it to ensure that the form contains all of the information requested: the name and address of the employee, employer, provider, and insurance carrier; the employee's social security number; the date of the employee's injury; the provider's specialty or area of practice; the treatment procedure to be reviewed; the date or dates of treatment to be reviewed; and an explanation why utilization review is being requested. 34 Pa. Code § 127.452(a); C.A. App. B34. Bureau staff also confirm that the date of treatment is on or after the effective date of the statute, 34 Pa. Code § 127.402; C.A. App. C33; that another party or workers' compensation judge has not already requested utilization review of the same treatment, C.A. App. C32; that the procedure for which review is requested matches the provider named, *id.* at C16; that the form, on its face, requests review of the reasonableness or necessity of medical treatment, *id.* at B98-B99; and that the insurer has accepted liability for a job-related injury, *id.* at C25-C27.

Bureau reviews the form only "to ensure that it is properly completed — *i.e.*, that all information required by the form is provided," and not in any way to "address the legitimacy or lack thereof of the request for utilization review." Pet. App. 5a; accord *id.* at 50a, 59a. The district court correctly found that the State has no involvement whatsoever in the substance of the decision either to seek utilization review or to withhold payments during that process (*id.* at 59a):

> The state takes no substantive step to promote, support, or encourage the decision of the insurer; and after the decision is made, the state takes no action which influences the ultimate substantive determination as to whether benefits are payable or not. The state does not significantly assist private actors when it merely provides a remedy, albeit complete with authorized forms and regulations. The state's acceptance and routing of forms completed in accordance with its instructions, in essence, * * * involves acquiescence and not compulsion on the part of the state.

The Third Circuit's statement that the State is "intimately involved in any decision by an insurer" to withhold payments (*id.* at 15a) is thus a gross exaggeration, at best.[12]

Pennsylvania's wholly ministerial role in accepting and routing the one-page form required to initiate utilization review falls well

[12] We hasten to add, however, that even if the Commonwealth engaged in a substantive evaluation of the merits of the request for utilization review, that would not transform the insurer's invocation of utilization review into state action. When the government limits, restricts, or regulates private action, it does not become responsible for that action.

short of the "overt, significant assistance" of state officials that is required for a finding of state action under this Court's "joint action" cases. *Tulsa Professional,* 485 U.S. at 486. For example, in *Shelley* v. *Kramer*, this Court found state action in the state court's *enforcement* of racially restrictive covenants entered into by private parties, but only because such enforcement was pursuant to state policy and placed the imprimatur of the State on the private, discriminatory conduct. 334 U.S. at 18-19.[13] There is nothing approaching such an imprimatur here. Most decisively, in *Blum* v. *Yaretsky*, this Court expressly rejected the argument that there was state action because New York required nursing home physicians to "complete patient care assessment forms and file them with state Medicaid officials." 457 U.S. at 1006-07, 1010. "We cannot say," the Court explained, "that the State, by requiring completion of a form, is responsible for the physician's decision." *Id.* at 1006-07.

Nor is the Third Circuit correct in stating (Pet. App. 15a) that there is "little difference between the approval required here and that necessary for utilizing a peremptory challenge * * * or for employing a nonclaim statute with the assistance of the probate court" as in *Leesville Concrete*, 500 U.S. 614, or *Tulsa Professional,* 485 U.S. 478. In those cases, a private party would be powerless to obtain the desired result without the intervention of the State. Private citizens do not empanel juries, and private citizens cannot cut off the claims of their creditors. Delay in paying disputed claims, by contrast, is a common insurer practice,

[13] *Shelley* arguably should be understood as resting on the fact that restrictions on alienation were generally disfavored under the common law of Missouri, and could be enforced only when the state court concluded that enforcement would be reasonable and consistent with public policy. For that reason, the State's decision to enforce the restrictive agreements amounted to a declaration that public policy was served by segregation. See L. TRIBE, CONSTITUTIONAL CHOICES 260 (1985).

permitted under private insurance contracts.[14] It is a self-help remedy, and can be accomplished without any involvement of the State at all. The requirement of filing a form is a (modest) *limitation* on the insurer's natural freedom of action; it is not a form of encouragement, assistance, or joint participation by the State.

4. The Private Insurers Are Not Fulfilling Constitutional Obligations Of The State

Finally, the Third Circuit purported to draw support for its state action holding from this Court's decision in *West* v. *Atkins*, 487 U.S. 42 (1987). Pet. App. 16a-17a. That reliance, however, was entirely misplaced. In *West*, this Court held that a physician under contract with the State to provide medical care to inmates at a state prison hospital was acting under color of state law even though he was not officially an "employee" of the State. The principle of the case is that the State may not evade a constitutional responsibility by contracting it out to a private party. The Third Circuit, however, interpreted *West* as permitting the court to engage in a loose examination of the "relationship" between the State and private parties and the "function" of the private party in deciding the state action question. *Id.* at 16a-17a, 19a.

That analysis overlooks the fact that *West* obviously turned on a factor not present here: the State had delegated one of its constitutional duties — provision of adequate medical care to inmates (see *Estelle* v. *Gamble*, 429 U.S. 97, 104 (1976); *West*, 487 U.S. at 54-57) — to a private party. Put differently, the physician's "function" and "relationship" the Court was referring to in *West* was his role as the State's delegate in discharging its constitutional obligations. Both this Court and the Courts of Appeals have recognized that *West* turned on this point and have rejected arguments to apply it outside that context. See *Georgia* v. *McCollum*, 505 U.S. 42, 52-53 (1992); *George* v. *Pacific-CSC*

[14] See, *e.g.*, 1 A. WINDT, INSURANCE CLAIMS AND DISPUTES: REPRESENTATION OF INSURANCE COMPANIES AND INSUREDS, § 2.22, at 75 (3d ed. 1995) (insurers may "withhold payment" of disputed portions of claims pending resolution of "dispute[s] as to the existence of coverage for a portion of the insured's claim").

Work Furlough, 91 F.3d 1227, 1232 (9th Cir. 1996), cert. denied, 117 S. Ct. 746 (1997); *Andrews* v. *Federal Home Loan Bank*, 998 F.2d 214, 218 (4th Cir. 1993).

B. The Third Circuit's Holding Is At Odds With This Court's Recent Decisions Involving Heavily Regulated Businesses

Finally, the Third Circuit's decision should be reversed because it squarely conflicts with key precedents of this Court, including *Jackson* v. *Metropolitan Edison Co.*, 419 U.S. 345 (1974), *Rendell-Baker* v. *Kohn*, 457 U.S. 830 (1982), and *Blum* v. *Yaretsky*, 457 U.S. 991 (1982). In *Jackson*, this Court held that the termination of electric service by a privately owned and operated utility corporation did not constitute state action, even though the utility was heavily regulated by the State, enjoyed "at least a partial monopoly in the providing of electrical service within its territory," and acted in terminating services pursuant to authority granted under a state-approved tariff. 419 U.S. at 354, 358. A private utility's "exercise of the choice allowed by state law" does not constitute state action, the Court explained, "where the initiative comes from it and not from the State." *Id.* at 357. The Court flatly rejected the contention that the utility was a state actor because it was "subject to extensive state regulation." *Id.* at 350. "The mere fact that a business is subject to state regulation," the Court reasoned, does not make it a state actor, even if "the regulation is extensive and detailed, as in the case of most public utilities." *Ibid.* Accord *Blum*, 457 U.S. at 1011; *Moose Lodge No. 107* v. *Irvis*, 407 U.S. 163, 176-77 (1972).

The Court in *Jackson* concluded there was no state action even though the utility company's termination decision was authorized by a general tariff that had been filed with the state public utility commission. The Court reasoned that there was "no * * * imprimatur placed on the practice of [the utility] about which [the utility customer] complains." 419 U.S. at 357. For the government to *allow* a private party to take some action is not the same as the government forcing or instigating that action. The Court explained:

> The nature of governmental regulation of private utilities is such that a utility may frequently be required by the state regulatory scheme to obtain approval for practices a business

> regulated in less detail would be free to institute without any approval from a regulatory body. Approval by a state utility commission of such a request from a regulated utility, where the commission *has not put its own weight on the side of the proposed practice by ordering it*, does not transmute a practice initiated by the utility and approved by the commission into "state action."

Ibid. (emphasis added).

In *Rendell-Baker*, this Court held that the decision of an extensively regulated private school for maladjusted high school students to discharge staff — allegedly in response to public criticism of the school leveled by the staff and without due process — was not state action even though the school received "virtually all of [its] income * * * from governmental funding," obtained its students through referrals from public schools and other public entities, and was required to comply with numerous educational requirements that applied to public schools. 457 U.S. at 840, 843. The Court observed at the outset that the school was not unlike many private corporations "whose business depends primarily on contracts" to provide services to the government, and explained that the "[a]cts of such private contractors do not become acts of the government by reason of their significant or even total engagement in performing public contracts." *Id.* at 840-41. Next, the Court rejected the argument that the schools were state actors because they were subject to detailed and extensive regulation. The Court not only reaffirmed the holding of *Jackson* that extensive regulation is insufficient to transform a private business into a state actor, but also suggested that much of the regulation to which the private school was subject was irrelevant to the state action question, because "the decisions to discharge" the staff "were not compelled or even influenced by any state regulation." *Id.* at 841.

The Court also rejected the argument that the school qualified as a state actor because it served a "public function," explaining that while "the education of maladjusted high school students is a public function, * * * that is only the beginning of the inquiry." 457 U.S. at 842. Under its cases, the Court explained, a private entity will be deemed a state actor only for carrying out a public function that is the "exclusive province of the State"; the mere fact

that the State had elected to pay for such education does not suffice. *Ibid.* The Court also dismissed the contention that the school was a state actor because it had a "symbiotic relationship" with the State. *Id.* at 842-43 (distinguishing *Burton* v. *Wilmington Parking Auth.*, 365 U.S. 715 (1961)).

Finally, in *Blum* the Court held that the decisions of private (but heavily regulated) nursing homes to discharge or transfer residents who were Medicaid recipients did not qualify as state action. The nursing homes were required by federal law to establish a utilization review committee ("URC") to determine on an ongoing basis whether the care provided to each patient was medically necessary. 457 U.S. at 994-95. If a URC determined that a patient needed a less intensive level of care, it was obligated to file a form containing information about its decision with the State, and the resident was transferred (without notice or an opportunity to be heard) to a facility with a lower level of care. *Id.* at 995. In holding that there was no state action, the Court again focused narrowly on the "specific conduct of which the plaintiff complains" — the decision to transfer or discharge — and concluded that this conduct was not something for which the government was responsible. *Id.* at 1004, 1008, 1010.

Reversal of the decision below follows *a fortiori* from *Blum*. *Blum* involved administration of a public program (Medicaid); this case involves a private contract of insurance to cover the legal liability of private employers. *Blum* involved a utilization review program in which nursing homes were required to inform the State if a patient's level of care became medically inappropriate; in this case the State merely authorizes utilization review but leaves it up to insurers whether and when to invoke it. If the actions of nursing homes administering a public program are not subject to constitutional constraints, workers' compensation insurers cannot possibly be deemed state actors.

For state action purposes, there is no analytical difference between the withholding of insurance payments under Pennsylvania law and the termination of electric service in *Jackson*, the discharge of staff in *Rendell-Baker*, or the reduction or termination of care through patient discharges or transfers in *Blum*. The Pennsylvania statute does nothing more than permit private parties to withhold

payments to health care providers during utilization review — something they are fully capable of doing without state assistance. The insurer's filing of a form with the State, and the State's forwarding a properly completed form to a utilization review organization, are purely formal steps in the process.

The Third Circuit sought to distinguish *Jackson*, *Blum*, and *Rendell-Baker* on the ground that those cases "do not * * * involve a comprehensive statutory scheme similar to that present in this case." Pet. App. 18a. But that statement is at odds with the essential holdings of *Jackson* and *Blum*. Both the public utility regulation in *Jackson* and the Medicaid regulation in *Blum* were as extensive as, if not more so than, insurer regulation in Pennsylvania. For example, insurers, unlike public utilities, are neither granted monopoly status nor required by the State to provide universal service. The crux of *Jackson* and *Blum* is their holding that extensive regulation — whatever its precise nature — *does not* transform private enterprises into state actors unless it compels or enforces the specific conduct at issue. That is an eminently sensible conclusion: where state legislators have crafted a comprehensive regulatory scheme, judicial second-guessing of particular components of that scheme is rarely either necessary or desirable. For the court below to dismiss *Jackson*, *Blum*, and *Rendell-Baker* on the ground that they did not involve a "comprehensive statutory scheme" was tantamount to rejecting this Court's holdings. Unless this Court is prepared to overrule those decisions — and the plaintiffs have never suggested that course — the decision below must be reversed.

II. AN INSURER'S WITHHOLDING OF PAYMENT TO HEALTH CARE PROVIDERS FOR DISPUTED MEDICAL TREATMENT DURING UTILIZATION REVIEW DOES NOT VIOLATE THE EMPLOYEE'S RIGHT TO DUE PROCESS

The second issue before this Court is whether the Due Process Clause permits an insurer (assuming it is a state actor) to delay payment of a medical bill for approximately two months while an independent utilization review organization determines whether the medical care for which the bill was submitted was reasonable and

necessary.[15] In the lower court, plaintiffs also successfully challenged certain features of the utilization review process itself, but petitioners have not sought review of those portions of the Third Circuit's decision. See pages 4-5 & n.3, *supra*; Pet. 22 n.12. The only issue before the Court is the constitutionality of the portion of 77 Pa. Stat. Ann.§ 531(5) that permits insurers to withhold payment for disputed medical care pending the outcome of utilization review.

Under Pennsylvania law, workers who have been injured on the job are entitled to "reasonable and necessary" medical treatment (which may include such unorthodox care as chiropractic manipulation, acupuncture, biofeedback therapy, physical therapy, and aquatic therapy). After the first ninety days following their initial treatment for injury, they obtain these services from the health care provider of their choice. The provider sends the bill directly to the workers' compensation insurance carrier, which is required to pay the bill within thirty days — *unless* the carrier questions the

[15] Petitioners urge this Court to reach the Third Circuit's due process holding even if it rules in petitioners' favor on state action. The State Workmen's Insurance Fund conceded before the Third Circuit that it is a state actor when it requests utilization review and withholds payment for disputed treatment pending its outcome, Pet. App. 12a, and the School District's status as a state actor has yet to be resolved. No. 97-2030 Pet. 5-6. Thus, the State Workmen's Insurance Fund, and possibly the School District, continue to be bound by the Third Circuit's due process ruling. If this Court were to rule in petitioners' favor on the state action issue but leave undisturbed the Third Circuit's due process ruling, public employers and insurers would be subject to an entirely different set of rules for obtaining utilization review than are private insurers, a highly disruptive result within the context of this integrated regulatory scheme.

Furthermore, if not reversed, the Third Circuit's due process holding as applied to state actors will likely cause substantial injury to private insurers. Public insurers or self-insuring public employers that are required to pay for unreasonable or unnecessary care pending utilization review are entitled to reimbursement from a special fund, which is maintained by annual assessments on all workers' compensation insurers. 77 Pa. Stat. Ann. § 999. Thus, the petitioners could ultimately bear much of the cost imposed by the Third Circuit's due process holding.

reasonableness and necessity of the treatment and submits the bill for review by an independent utilization review organization. Under Pennsylvania law (like that of 25 of 27 States whose utilization review provisions address the subject[16]), insurers are permitted to withhold payment of disputed bills pending this review, with an obligation to pay promptly and with 10% interest if the utilization reviewer concludes the treatment was proper.

The Third Circuit held this provision unconstitutional on the theory that the delay in payment was tantamount to a denial of benefits, and thus in violation of *Mathews* v. *Eldridge*, 424 U.S. 319 (1976). Because a delay in payment is tantamount to a denial of benefits, so the theory goes, it is unconstitutional to allow the insurers unilaterally to invoke the utilization review process and withhold payment. There must be notice and an opportunity to be heard before the "deprivation," which is to say before the delay in payment. Under this reasoning, the insurer must pay the disputed claim within the ordinary 30-day period for undisputed payments and before the utilization review can take place. Since Pennsylvania prohibits insurers from recouping payments to medical providers once made, the holding below means that medical providers receive payment whether or not the treatment they provided was reasonable and necessary.

This decision defies both legal doctrine and common sense. We will offer three separate but related reasons why. First, the individual claimants have not suffered a "deprivation" in the sense that term is used in *Goldberg* v. *Kelly*, 397 U.S. 254 (1970), and its progeny. Unlike the claimant in *Goldberg*, the individual plaintiffs' eligibility for benefits has not been terminated or even challenged. They have received the medical care to which they are arguably entitled. All that is at issue is whether their health care providers will be paid — or more precisely, *when* their providers will be paid. Second, even if the individual plaintiffs could be said to have suffered a deprivation, the process provided easily passes

[16] See S. ECCLESTON & C. YEAGER, WORKERS' COMPENSATION RESEARCH INSTITUTE, MANAGED CARE AND MEDICAL COST CONTAINMENT IN WORKERS' COMPENSATION, A NATIONAL INVENTORY, 1997-1998, at 18-19, 72 (1997).

muster under the three-part test of *Mathews*, 424 U.S. at 335. Third, to the extent that the due process balance takes its bearings from longstanding tradition and the practices of other states, it was extraordinary for the court below to hold unconstitutional a practice that accords with common law practice and is currently in use in the vast majority of the states.

A. Workers' Compensation Beneficiaries Have Not Suffered A "Deprivation" When Insurers Delay Payment Of Their Health Care Providers' Bills

A delay in payment pending utilization review cannot be characterized as a deprivation of the employee's property interest. Employees do not have the right to challenge the procedures used to determine the eligibility of third party providers, such as health care providers, for payment — even if employees suffer serious indirect consequences from such a determination. In addition, determination of the reasonableness and necessity of particular medical treatments does not affect the workers' legal entitlement, which is to receive reasonable and necessary medical care. It is more analogous to a decision about an initial application for benefits (which does not require interim payments under *Mathews*) than to a termination of eligibility for benefits.

1. Employees Have No Right To Challenge The Procedures Used To Determine The Eligibility Of Their Health Care Providers For Payment

This case was brought by or on behalf of injured workers entitled to medical treatment as part of their workers' compensation benefits. Yet the gravamen of the employees' case is that their health care providers have not been promptly paid for services already rendered. Plaintiffs assert, and the court below agreed, that the effect of this delay in payment is that the medical providers will terminate their medical treatment. Pet. App. 27a. In Section II.B.2, we will demonstrate that this assertion is factually incorrect. But a more fundamental objection to the plaintiffs' claim is that the Due Process Clause, as interpreted in *Goldberg* and its progeny, provides protection only for persons whose own legal entitlements are directly subject to revocation. It does not give them any right to challenge the procedures applicable to third-party providers.

This principle was articulated most clearly in *O'Bannon* v. *Town Court Nursing Center*, 447 U.S. 773, 786-87 (1980). *O'Bannon* involved a group of elderly patients who were eligible for Medicaid benefits and who brought suit after their nursing home was found to have violated the requirements for certification as a Medicaid provider. *Id.* at 776-78. As a result of decertification, the nursing home could not receive payment for the care of Medicaid patients, and the patients were subject to mandatory transfer to a certified facility. *Id.* at 777, 780, 784 & n.16. Despite the obvious risk of emotional and physical harm to the patients that would flow from the nursing home's decertification, the *O'Bannon* Court explained that the patients had no constitutionally protected interest in certification of the home. The Court distinguished between "direct" benefit determinations — which involve the application of statutory or regulatory criteria to individuals themselves — and "indirect" benefit determinations — which involve the application of statutory or regulatory criteria to a third-party provider of services or benefits. *Id.* at 786-87. Where the third-party providers were the subject of regulation rather than the patients themselves, the Court explained, the patients had no protected interest in the regulatory outcome. *Id.* at 790.

Notably, the *O'Bannon* Court rejected the argument that the likelihood of injury resulting from decertification of the nursing home gave patients a constitutional right to participate in decertification proceedings. Although Justice Blackmun argued in his concurring opinion that indirect beneficiaries have a protected liberty interest where challenged procedures would cause them a "high risk of death or serious illness," 447 U.S. at 803, the majority opted instead for a bright-line distinction between direct and indirect beneficiaries. *Id.* at 787. Direct beneficiaries, who are the subject of the challenged decision, may be entitled to due process protections. *Id.* at 786-87. Indirect beneficiaries, who are not the subject of the challenged decision, have no protected interest in its outcome, even if they suffer an "immediate, adverse impact" from the challenged decision and even if the underlying program is intended solely for their benefit. *Id.* at 787. The *O'Bannon* Court *assumed* that decertification of the nursing home would cause patients "severe emotional and physical hardship" and

injury. *Id.* at 784 n.16, 787. Despite this proximate but indirect link between decertification and injury to the patients, the Court held that the patients had no due process interest in certification. *Id.* at 790.

O'Bannon thus presented an entirely different type of claim than that in *Goldberg*. In *Goldberg*, the claimant's own eligibility for benefits was at stake. In *O'Bannon*, the legal rights of a third party were directly at issue, and the effect on the claimant was indirect (even if powerful).

This Court's analysis in *O'Bannon* governs this case. Just as the patients in *O'Bannon* sought to challenge the decertification of the nursing homes where they resided because decertification would force them to move, plaintiffs in this case seek to challenge the delay in payment to their health care providers out of fear that the providers will no longer provide them treatment. In both cases, the claimants are only indirectly affected by application of rules that are intended to regulate the practices of their nursing homes or health care providers — here, in order to prevent excessive costs for unreasonable and unnecessary medical treatment. Under *O'Bannon*, therefore, plaintiffs have no protected interest in their providers' bill payment dispute, regardless of the practical consequences to the employees.[17]

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[17] Section 8, the federal low-income housing assistance program, 42 U.S.C. § 1437f, contains a similar dual regulatory scheme. Under Section 8, the federal government makes payments directly to landlords on behalf of eligible tenants. See *Cisneros* v. *Alpine Ridge Grp.*, 508 U.S. 10, 12 (1993). In order to become and remain qualified as a Section 8 provider, a landlord must meet "housing quality standards for decent, safe, and sanitary housing." 42 U.S.C. § 1437f(o)(5). The lower courts have consistently held that tenants have a constitutionally protected interest in continued eligibility for Section 8. See *Davis* v. *Mansfield Metro. Hous. Auth.*, 751 F.2d 180, 184 (6th Cir. 1984), and cases cited therein. No court has ever held, however, that tenants have a right to notice and an opportunity to be heard before their landlord is disqualified for failure to maintain "decent, safe, and sanitary housing" — despite the fact that the latter determination will result in the termination of rental payments on behalf of the tenant. At least one court has recognized that such a claim would be barred by *O'Bannon*. See *Swann* v. *Gastonia Hous. Auth.*, 502 F. Supp. 362, 366 (W.D. N.C. 1980).

The Third Circuit's equation of a delay in payment to a provider with a deprivation of benefits to a patient threatens to expand radically the scope of due process protection. Virtually every government decision has foreseeable, and sometimes dire, consequences for persons other than the direct target of the decision. Terminating a university's accreditation, for example, would imperil its students' eligibility for grants and loans. Terminating a social service provider's eligibility for government funding is likely to injure those depending on its services. Disqualifying a Medicare or Medicaid provider on the basis of fraud will almost certainly cause harm to the provider's patients, who will be required to find a new provider or pay out-of-pocket for continued care. Under the Third Circuit's reasoning, each of these indirectly affected third parties is entitled to notice and an opportunity to be heard prior to the adverse decision. As the *O'Bannon* Court explained, due process has never been understood to reach so broadly. 447 U.S. at 778-89.

2. Procedures For Determining The Reasonableness And Necessity Of Heath Care Services Are More Analogous To An Initial Application For Benefits Than To A Termination Of Eligibility For Benefits

Under Pennsylvania law, an employee who is injured in the course of employment is entitled to benefits under the Pennsylvania Workers' Compensation Act, including replacement wages, compensation for permanent injury or disability, and payment to health care providers for treatment of the injury. 77 Pa. Stat. Ann. §§ 431, 531. An employee's eligibility for workers' compensation benefits does *not* mean, however, that the insurer must pay for any and all health care provided to the employee. Pennsylvania law expressly limits an employee's entitlement to reimbursement of the provider for medical care and services that are both "reasonable and necessary." *Id.* § 531(1), (5).

Administration of the workers' compensation system thus requires two separate steps: first, determining whether an employee is eligible for workers' compensation benefits; second,

determining whether a particular medical bill submitted for reimbursement falls within the scope of the employee's right to provider reimbursement for medical benefits. If the insurer attempted to reconsider the *first* step — to declare the worker no longer eligible for workers' compensation benefits — we concede that (state action issues aside) this case would bear a resemblance to *Mathews*.[18]

The *second* step — determining the reasonableness and necessity of a particular medical treatment — is unrelated to the employee's overall eligibility for workers' compensation benefits. Each of the individual plaintiffs in this case remained eligible for continued benefits at all times after suffering a job-related injury, and nothing in the utilization review procedures could adversely affect their continued eligibility. In order to invoke utilization review, an insurer must concede the employee's eligibility for workers' compensation benefits. 34 Pa. Code §§ 127.404(b)-(d), 127.405(c), 127.479. A utilization reviewer is not permitted to consider issues that bear on the employee's eligibility, such as whether the patient's injury or disease is job-related or whether the patient's disability still exists. *Id.* §§ 127.406, 127.470. The *only* question at issue in the decision to request utilization review, and in the utilization review itself, is whether a particular medical treatment falls within the scope of the provider's right to reimbursement for reasonable and necessary medical expenses.

Goldberg, *Mathews*, and their progeny are therefore inapplicable to this case. In *Goldberg*, the named plaintiffs had met the criteria to receive and had been receiving financial aid under Aid to Families with Dependent Children and/or Home Relief. 397 U.S. at 256 & n.2. Similarly, in *Mathews*, the plaintiff had been

[18] Even a challenge to an employee's overall eligibility for workers' compensation benefits would not appear to require the full panoply of procedural protections mandated in *Goldberg*. The challenge would be more similar to the termination of disability benefits at issue in *Mathews* than the termination of welfare benefits in *Goldberg* because, as the district court noted, eligibility for workers' compensation benefits is not based on financial need and an injured employee may have other sources of income. Pet. App. 69a-70a.

found eligible for Social Security disability benefits and had been receiving those benefits for nearly four years. 424 U.S. at 323-24. In both cases, the government sought to change — to *terminate* — these previously established legal rights of the claimant, and the Court was accordingly required to decide what procedures were constitutionally mandated before an aid recipient could be divested of those rights. See *id.* at 332; *Goldberg*, 397 U.S. at 260.

In this case, by contrast, there has not been (indeed, could not be) a prior determination that the claimant was entitled to any particular medical service. That is an issue that generally can be resolved only retrospectively,[19] and only with reference to the particular course of treatment. Utilization review thus does not result in the loss of a vested right, but is an initial determination of whether the particular service falls within the scope of the worker's entitlement. It is more closely analogous to an initial application for a benefit.[20] The employee has no vested entitlement to provider payment for a particular medical service until it is first determined to be "reasonable and necessary." As a consequence, there is no right to due process because there has been no deprivation of a protected right by virtue of the insurer's withholding of payment.

The flaw in the plaintiffs' logic is plain when one considers what would happen if Pennsylvania modified its procedures for reimbursement. Pennsylvania could provide that no bills are to be reimbursed until a utilization reviewer determines that the bill is for

[19] Although Act 44 provides for prospective and concurrent utilization review, 77 Pa. Stat. Ann. § 531(6)(i), an insurer does not know prior to submission of a bill what medical services are being provided unless the provider or employee has asked for pre-approval of a particular course of treatment.

[20] This Court has never decided whether "applicants for benefits, as distinct from those already receiving them, have a legitimate claim of entitlement protected by the Due Process Clause * * *." *Lyng* v. *Payne*, 476 U.S. 926, 942 (1986); see also *Walters* v. *National Ass'n of Radiation Survivors*, 473 U.S. 305, 312, 320 n.8 (1985); *Gregory* v. *Town of Pittsfield*, 470 U.S. 1018, 1021 (1985) (O'Connor, J., dissenting from denial of certiorari); *Peer* v. *Griffeth*, 445 U.S. 970, 970 (1980) (Rehnquist, J., dissenting from denial of certiorari).

reasonable and necessary medical care. Pennsylvania could set a 60-day limit for making this decision, the same length of time given under current law for an insurer to deny reimbursability and for utilization review to take place. 77 Pa. Stat. Ann. §§ 531(5), (6)(ii). An argument that due process required the payment of bills during this 60-day period, before any determination of the reasonableness or necessity of the medical care at issue, would be frivolous. Yet in substance, this hypothetical procedure is identical to the actual Pennsylvania system, with the sole exception that insurers are required to pay *undisputed* bills within 30 days. This demonstrates that plaintiffs have not been subjected to deprivation of any legal right.

B. The Procedures Involved In This Case Easily Satisfy Due Process Under The *Mathews* Balancing Test

Even if one were to ignore the foregoing analysis and assume, contrary to law, that an insurer's decision to withhold payment deprives an employee of a protected right, due process does not require insurers to pay bills for disputed treatment pending the results of utilization review. In determining whether procedures are constitutional, the Court traditionally considers the private interests that will be affected, including the interests of both the party subject to official action and the party seeking the action;[21] the risk of an erroneous deprivation and the probable value, if any, of additional procedural safeguards; and the government's interest. *Connecticut* v. *Doehr*, 501 U.S. 1, 10-11 (1991); *Brock* v. *Roadway Express, Inc.*, 481 U.S. 252, 263 (1987); *Mathews* v. *Eldridge*, 424 U.S. 319, 335 (1976). The Court must also consider the brief duration of any deprivation, which weighs in favor of constitutionality. *Gilbert* v. *Homar*, 117 S. Ct. 1807, 1813 (1997) (in performing *Mathews* balancing, "account must be taken of 'the length' and 'finality of the deprivation'" in determining what process is due) (quoting *Logan* v. *Zimmerman Brush Co.*, 455 U.S. 422, 434 (1982)); *Santosky* v. *Kramer*, 455 U.S. 745, 758 (1982).

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[21] The Third Circuit simply ignored the private interests of Pennsylvania workers' compensation insurers in retaining the statutory right to deny reimbursement for disputed care pending utilization review. See Pet. 23-24; Pet. Reply Br. 7.

On balance, these factors strongly support the conclusion that permitting the insurer to withhold payment for disputed treatment pending the outcome of utilization review comports with "fundamental fairness." *Lassiter* v. *Department of Soc. Servs.*, 452 U.S. 18, 24 (1981).

1. The Insurer's Interest

The insurer has a substantial private interest in not paying for unnecessary or unreasonable medical treatment pending the outcome of utilization review. Under Pennsylvania law, an insurer is not permitted to recoup payments for unreasonable or unnecessary care. *Moats* v. *Workmen's Compensation Appeal Bd.*, 588 A.2d 116, 118 (Pa. Commw. Ct. 1991). Although insurers may seek reimbursement for excessive payments from a special fund, the fund is financed entirely from assessments levied on the insurers (and self-insured employers) themselves. 77 Pa. Stat. Ann. § 999. Thus, insurers — and ultimately employers and consumers — bear the cost of all payments for unnecessary and unreasonable treatment.

Utilization review — or some equivalent procedure — is essential for the prevention of fraud and abuse in the workers' compensation medical care system. Utilization review developed in response to academic studies demonstrating that "a significant fraction of medical care is inappropriate and unnecessary." Leape, *Practice Guidelines and Standards: An Overview*, QUALITY REVIEW BULLETIN 42, 42 (Feb. 1990); see also Kelly & Kellie, *Appropriateness of Medical Care*, 114 ARCH. PATHOL. LAB. MED. 1119, 1119 & nn.1-9 (1990).[22] Traditional fee-for-service plans give

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[22] One study found that utilization review reduced total medical expenditures by 8.3%. See Feldstein, *et al.*, *Private Cost Containment: The Effects of Utilization Review Programs on Health Care Use and Expenditures*, 318 NEW ENG. J. MED. 1310, 1312, 1314 (1988); see also Wickizer, *The Effect of Utilization Review on Hospital Use and Expenditures, in* REVIEW, REGULATE OR REFORM: WHAT WORKS TO CONTROL WORKERS' COMPENSATION COSTS 108, 133 (1994) (summarizing studies of hospital utilization review under federal benefit programs and concluding that utilization review "reduces hospital inpatient days by somewhere between 5 and 10 percent"). The Pennsylvania Compensation Rating Bureau has recently estimated the "net direct savings attributable

health care providers a financial incentive to provide medical care and services that do not improve patient health. See, *e.g.*, Walsh, *The Legal Attack on Cost Containment Mechanisms: The Expansion of Liability for Physicians and Managed Care Organizations*, 31 J. MARSHALL L. REV. 207, 214 (1997); Danzon, *Tort Liability: A Minefield for Managed Care?*, 26 J. LEGAL STUD. 491, 493 (1997) ("Customary care under traditional insurance reflects severe moral hazard and hence overuse of costly services.").

The incentive to overuse medical services is heightened in the workers' compensation context, where medical insurance features that are used to discourage overutilization — such as employee-paid deductibles, co-payments, or dollar or duration limitations — are barred by state law requiring a workers' compensation insurer to pay the full cost of reasonable and necessary medical services. 77 Pa. Stat. Ann. § 531(1), (5). As a result, "[p]roviders have shifted costs from increasingly restrictive group health payers to less restrictive workers' compensation payers, primarily by providing more intensive and longer duration services to workers' compensation patients." Tracy, *The Importation of Managed Care to the Workers' Compensation System: Time for Re-evaluation and Redirection*, 9 NO. 7 HEALTH LAW 16, 17 (1997); see also PA. LEGIS. J. — HOUSE, at 2020 (Dec. 11, 1991) (statement of Rep. Murphy, advocating adoption of medical cost-containment for workers' compensation because "the place where the health care costs are now moving to is to workers' compensation" in response to cost-containment in other health care programs). To make matters worse, employees may have an incentive to continue receiving medical care (regardless of its medical efficacy) in order to delay clearance to return to work, a particular problem in Pennsylvania since one-third of injured workers receive wage replacement benefits that are greater than their actual pre-injury wages. See D. BALLANTYNE, *supra*, at 25. Similarly, by consuming additional

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to utilization review before the Sullivan decisions at approximately $32 million per year," with even larger "indirect" effects. Letter from Timothy L. Wisecarver, President, Pennsylvania Compensation Rating Bureau, to Richard Himler, Director, Bureau of Workers' Compensation, Dep't of Labor & Industry, Commonwealth of Pennsylvania (Oct. 29, 1998), posted at <http://www.li.state.pa.us/wcletter.html>.

medical care and services, a worker may become eligible for a larger award for permanent disability.

Even under the current system, it is financially infeasible for insurers to invoke utilization review in every instance of unreasonable or unnecessary care, because the insurer must pay the cost of utilization review. 77 Pa. Stat. Ann. § 531(6)(iii). If the insurer is required to pay all bills received before the conclusion of utilization review of a particular course of treatment, the direct benefit of review will disappear, since the insurer is not permitted to recoup reimbursement later determined to have been wrongful. Requiring payment of bills pending the outcome of utilization review thus substantially reduces the financial incentive for medical providers to limit themselves to reasonable and necessary care.

2. The Employee's Interest

The employee has an interest in timely reimbursement to his or her provider for reasonable and necessary medical care.[23] Because the medical care has already been provided, the employee's interest is attenuated,[24] but it stands to reason that greater uncertainty about payment could affect future treatment. Contrary to the arguments of plaintiffs and the assumption of the court below, however, a delay in payment is far from equivalent to a termination of medical care.

In light of the incentives of the system, an insurer will withhold payments only when it has reason to believe that the utilization reviewer, a neutral medical professional in the provider's own specialty, will conclude that the treatment was contrary to accepted medical protocols *and* when the amount saved by this determination will be greater than the cost of the utilization review.

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[23] As discussed above, this interest, being indirect, is not legally sufficient to give the claimant a right to challenge the procedures under *O'Bannon* v. *Town Court Nursing Ctr.*, 447 U.S. 773 (1980). See pages 32-35, *supra*. In this section, we show why plaintiffs' claim would fail even if it could survive that threshold difficulty.

[24] The real party in interest is the medical provider, but no one would argue that the provider's due process rights are violated by the relatively brief delay in payment at issue here.

By the same token, a health care provider who believes that the care he or she is providing is medically necessary has every financial incentive — in addition to any ethical and professional obligations — to continue care, since a provider whose treatment decisions are upheld on utilization review is entitled to full retroactive payment with 10% annual interest. 77 Pa. Stat. Ann. § 717.1(a); 34 Pa. Code § 127.210. Thus, a provider will likely stop treatment during the pendency of utilization review *only* if he or she expects an adverse review.[25] This inference is borne out by the actual experience of the named plaintiffs: at least five of the ten individual plaintiffs continued to receive disputed treatment months or even years after a request for utilization review. See J.A. 29, 30, 34, 36, 38. Moreover, even if the provider does discontinue treatment, the worker (who remains eligible for care) can go to another provider. If that provider provides reasonable and necessary care, the worker may be better off for the change. Finally, a patient who wishes to continue receiving a certain form of treatment even if it is found to be unreasonable or unnecessary can pay out-of-pocket to do so, as at least one of the named plaintiffs chose to do. See *id.* at 42. All these factors serve to protect the employee's interest in continued care.

3. The Value Of The Additional Safeguard

Obviously, employees (and their health care providers) would prefer to receive immediate payment for all treatment, without any scrutiny whatsoever. But for purposes of the due process balance, the proper question is to what extent requiring immediate payment will reduce the number of cases in which an injured worker's reasonable and necessary medical treatments have been erroneously terminated as a result of the delay in payment. Respondents have provided no reason to believe that that number is substantial, and there is every reason to believe that it is not.

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[25] Under 77 Pa. Stat. Ann. § 531(7), a provider is prohibited from "balance billing" an employee — attempting to collect the difference between the amount billed and the amount reimbursed by the insurer — for medical services determined to be unreasonable or unnecessary. See also 34 Pa. Code § 127.211 ("Balance billing prohibited").

An insurer that invokes utilization review and withholds payments must pay the entire cost of the review (regardless of its outcome) and must pay the entire bill, with 10% interest, if it is found to be necessary and reasonable, in a proceeding in which the insurer bears the burden of proof (see 34 Pa. Code § 127.471(b)). In light of these incentives, it is likely that insurers will invoke the procedure only when they have very strong reasons to think that their view of the treatment will prevail. In fact, according to statistics compiled by the State, 69.14% of the requests for utilization review through early 1998 were found to involve medical care that was wholly or partially unreasonable or unnecessary. Letter from Timothy L. Wisecarver, President, Pennsylvania Compensation Rating Bureau, to Richard Himler, Director, Bureau of Workers' Compensation, Dep't of Labor & Industry, Commonwealth of Pennsylvania (July 1, 1998), posted at <http://www.li.state.pa.us/wcletter.html>.[26] The great likelihood that a denial of reimbursement by an insurer will be upheld on utilization review supports the conclusion that no additional procedures are required. See *FDIC* v. *Mallen*, 486 U.S. 230, 242 (1988) (permissible length of delay before post-deprivation hearing depends on "likelihood that the interim decision may have been mistaken").

Moreover, it stands to reason that the cases in which the treatment is reasonable and necessary are the cases in which it is most likely that the providers would continue to provide services in the expectation that they will receive full retroactive payment with interest. Requiring immediate payment of disputed bills would therefore be tremendously costly and would greatly increase the incidence of health care fraud and abuse by providers, without significantly reducing the number of cases in which workers are deprived of necessary and reasonable medical services.

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[26] A copy of the July 1, 1998 Wisecarver letter was also lodged with the Office of the Clerk of the Supreme Court by *amicus curiae* American Insurance Ass'n *et al.*, simultaneous with the filing of their Brief in Support of the Petition for Certiorari, and is included as an Appendix to that Brief.

4. The Government's Interest

The government has substantial interests in permitting insurers to withhold payment for disputed treatment pending utilization review. As a regulator, the government has an interest in containing costs for Pennsylvania employers and insurers that participate in the workers' compensation program, in order to ensure the economic health of the business community and encourage in-state investment. Act 44 was "intended to greatly curtail the escalating medical costs associated with work-related injuries and illnesses." Dep't of Labor & Industry, *Workers' Compensation Medical Cost Containment,* PENNSYLVANIA BULLETIN 4875 (Vol. 25, No. 45, Nov. 11, 1995). Medical payments dropped 25% in the year after Act 44 was enacted, and as of 1996 employers had received average rate reductions of 18%. *Workers' Compensation Reform,* posted at <http://www.state.pa.us./PA_Exec/ Governor/wcleg3.html>.

This governmental interest goes beyond the interest of individual insurance companies in avoiding payment for unreasonable or unnecessary medical bills. The existence of an effective utilization review mechanism serves both as a deterrent to fraudulent and abusive claims and as a source of guidance and information to providers about what services are properly regarded as medically reasonable and necessary (and thus reimbursable). The Pennsylvania Compensation Rating Bureau has estimated these "indirect" effects of utilization review as "potentially much greater than the direct effects of these decisions" because "many more claims may be affected by such precedents [set by utilization reviews] than are required to establish them." Letter from Timothy L. Wisecarver, President, Pennsylvania Compensation Rating Bureau, to Richard Himler, Director, Bureau of Workers' Compensation, Dep't of Labor & Industry, Commonwealth of Pennsylvania (Oct. 29, 1998), posted at <http://www.li.state.pa.us/wcletter.html>. If insurers receive no direct benefit from undertaking utilization review (because, under the decision below, they have to pay the bill for the disputed treatment before the review takes place and cannot obtain recoupment), they are far less likely to do so. This negates the indirect benefits of utilization review for the entire system. Since the Third Circuit's decision, the number of utilization review requests has declined by almost 60%. *Ibid.*

The government's interest in cost containment is entitled to great weight. See *Parham* v. *J.R.*, 442 U.S. 584, 604-05 (1979) (State "obviously has a significant interest in confining the use of its costly mental health facilities to cases of genuine need"); *Mathews* v. *Eldridge*, 424 U.S. 319, 348 (1976) (noting government and public interest "in conserving scarce fiscal and administrative resources"). As the Court recognized in *Mathews*, requiring interim benefit payments to a recipient who ultimately is found to be undeserving "may in the end come out of the pockets of the deserving since resources available for any particular program of social welfare are not unlimited." 424 U.S. at 348; see also Friendly, *Some Kind of Hearing*, 123 U. PA. L. REV. 1267, 1276 (1975).

In addition, the government has significant interests in controlling the medical care given to Pennsylvania residents. This interest encompasses both a *parens patriae* interest in protecting employees from unreasonable or unnecessary medical procedures, see *Walters* v. *National Ass'n of Radiation Survivors*, 473 U.S. 305, 323 (1985); *Parham*, 442 U.S. at 605, and a regulatory interest in ensuring that medical care provided to Pennsylvania residents complies with professional standards, see, *e.g.*, *Bigelow* v. *Virginia*, 421 U.S. 809, 827 (1975) (state has a "legitimate interest in maintaining the quality of medical care provided within its borders").

5. The Interest Balance

The balancing of interests in this case weighs decisively in favor of permitting an insurer briefly to withhold payment for disputed treatment pending the results of utilization review. The minor risk of an erroneous delay in payment for treatment that is reasonable and necessary, and the consequent possibility that a provider will discontinue reasonable and necessary treatment because of this delay, is greatly outweighed by the interests of the private insurer and government in permitting suspension of payment for disputed care.

A comparison with this Court's treatment of similar regulatory systems is instructive. In *United States Department of Labor* v. *Triplett*, 494 U.S. 715 (1990), for example, this Court upheld the constitutionality of federal regulations governing attorneys' fees in

black lung benefit cases under which an attorney was not permitted to accept any fees unless and until the claimant was successful in applying for benefits and all appeals had been resolved. *Id.* at 717. In applying the *Mathews* balancing test, the Court emphasized that delaying payment of fees until the conclusion of administrative proceedings and possible judicial review protected the employer, the insurance carrier, and the Black Lung Disability Trust Fund "from a depletion that would leave other claimants without a source of compensation." *Id.* at 722. The Court further noted that requiring payment of fees to an attorney "immediately upon success at every level, subject to recovery in the event the judgment in favor of the claimant is reversed at a higher level, would impose upon the payor the onerous task of seeking to obtain a refund." *Ibid.*[27] Thus, the Court concluded, the delay in payment of fees was fully consonant with due process. *Id.* at 726.

In *Heckler* v. *Ringer*, 466 U.S. 602, 619 (1984), this Court held that Medicare recipients challenging the denial of payment for surgery were required to exhaust an "often lengthy administrative review process" before seeking a judicial ruling that the surgery was "reasonable and necessary." If the lengthy delay in *Ringer* is permissible — despite the fact that, as the *Ringer* Court acknowledged, "some * * * surgeons may well decline to perform the requested surgery because of fear that the Secretary will not find the surgery 'reasonable and necessary' and thus will refuse to reimburse them," *id.* at 626 — then surely the extremely brief delay in payment at issue in this case is likewise permissible.

And in *Schweiker* v. *McClure*, 456 U.S. 188 (1982), this Court rejected a due process challenge to the regulations governing Medicare Part B reimbursement. Under the regulatory scheme at issue in *McClure*, health care providers who treated patients enrolled in Medicare Part B were required to submit bills to a private insurance carrier. *Id.* at 190-91. The carrier reviewed the bill and, if it found that the treatment was not medically necessary,

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[27] This reasoning applies *a fortiori* to this case, since workers' compensation insurers are precluded by law from recovering erroneous payments to medical providers. See page 3-4, *supra*. Thus, seeking a refund would be not only "onerous" but impossible.

denied payment subject to subsequent administrative review. *Id.* at 191. There was absolutely no hint in the Court's opinion that any delay in payment resulting from this procedure might violate due process. As the Court noted, "[a]ppellees simply have not shown that the procedures prescribed by Congress and the Secretary are not fair * * *." *Id.* at 200.

Triplett, *Ringer*, and *McClure* mandate the conclusion that due process permits the withholding of payment for disputed medical services pending the outcome of utilization review. Just as the attorneys in *Triplett* and the physicians in *Ringer* and *McClure* were required to bear the substantial burden of a delay in payment pending a final determination that payment should be made, so must health care providers under Pennsylvania's workers compensation system assume the modest risk that payment for reasonable and necessary services will be briefly delayed. But that risk is vastly outweighed by the risk on the other side — that the workers' compensation system would be required to pay for fraudulent, unnecessary, unreasonable, or otherwise abusive medical bills, with no hope of recovery. Requiring payment for disputed treatment pending utilization review is a classic example of a scenario in which "the marginal gains from affording an additional procedural safeguard * * * [are] outweighed by the societal cost of providing such a safeguard." *Walters*, 473 U.S. at 320-21.

C. Withholding Of Payment Pending Resolution Of Coverage Issues Comports With Traditional Practice Under State And Federal Law

The conclusion that due process permits the suspension of payment for disputed medical treatment pending review is buttressed by an examination of the "[h]istorical and contemporary practices" of other States. See *Doehr*, 501 U.S. at 16. As this Court has emphasized "from its first due process cases, traditional practice provides a touchstone for constitutional analysis." *Honda Motor Co.* v. *Oberg*, 512 U.S. 415, 430 (1994). The Court reiterated this principle just two Terms ago in *Washington* v. *Glucksberg*, 117 S. Ct. 2258 (1997), stating that "in all due-process cases," the "Nation's history, legal traditions, and practices * * * provide the crucial guideposts for responsible decisionmaking that

direct and restrain our exposition of the Due Process Clause."[28] *Id.* at 2262, 2268 (citations omitted). Where a practice enjoys the support of a large majority of the States, and the imprimatur of long experience, this Court has been extremely reluctant to strike it down under the Due Process Clause. See, *e.g.*, *Schall* v. *Martin*, 467 U.S. 253, 266-67 (1984); *Glucksberg*, 117 S. Ct. at 2269; *Burnham* v. *Superior Court*, 495 U.S. 604, 615 (1990) (plurality opinion).

Interpreted against "th[e] backdrop of history, tradition, and practice" (see *Glucksberg*, 117 S. Ct. at 2267), there can be no question that the challenged Pennsylvania scheme is constitutional. To begin with, reasonable delay to permit evaluation of disputed claims is a common insurer practice — and one permitted by private insurance contracts as enforced under the common law. See note 14, *supra*. Respondents' claim is equivalent to suggesting that the Constitution requires insurers (if state actors) to pay disputed claims *before* an independent decisionmaker determines whether they are covered by the governing contract. That has never been the law in *any* jurisdiction, much less a requirement of the Constitution.

Nor is Pennsylvania law inconsistent with modern practice under other States' laws. To the contrary, of the 41 States (and the District of Columbia) whose statutes or regulations specifically address the subject, at least 39 (including Pennsylvania) permit insurers to withhold disputed claims during the pendency of utilization review or the resolution of various disputes regarding the scope of treatment or amount of compensation. See S. ECCLESTON & C. YEAGER, WORKERS COMPENSATION RESEARCH INSTITUTE, MANAGED CARE AND MEDICAL COST CONTAINMENT IN WORKERS' COMPENSATION, A NATIONAL INVENTORY, 1997-1998, at 18-19

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[28] *Glucksberg* was a substantive due process case, but it specifically made this point with reference to "all due-process cases." 117 S. Ct. at 2262. Indeed, the emphasis on practice and tradition arose in this Court's earliest due process cases, which were procedural in nature. *Murray's Lessee* v. *Hoboken Land & Improvement Co.*, 59 U.S. (18 How.) 272, 277 (1856); *Missouri Pac. Ry. Co.* v. *Humes*, 115 U.S. 512, 521 (1885); *Hurtado* v. *California*, 110 U.S. 516, 535 (1884).

(1997).[29] Likewise, numerous States authorize unilateral suspension of payments for other reasons, such as when an employee returns to work, refuses to submit to reasonable medical examination, or declines to attend vocational rehabilitation or counseling. See Pet. 15 n.6 (collecting statutory authorities). Courts in at least five of the remaining ten States go even further, holding that insurers (or employers) may withhold payment without penalty *whenever* there exists a good faith belief that no payment is due. See *id.* at 24-25 (collecting authorities). The law in Pennsylvania thus accords with the "settled usages and modes of proceeding" in nearly all of the other States. *Hurtado* v. *California*, 110 U.S. 516, 528 (1884).

At the federal level, the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. § 901 *et seq.*, permits insurers that voluntarily initiate benefits to injured workers subsequently to challenge the reasonableness or necessity of the workers' medical care. Federal regulations authorize the insurers to withhold payment and request government review of controverted treatment (20 C.F.R. § 702.233), and they are not required to give workers an opportunity to be heard before doing so. *Ibid.* Thus, viewed in light of both federal and state law, the subject statute involves not the slightest "deviation from established procedures," much less one "result[ing] in constitutional infirmity." *Oberg*, 512 U.S. at 430. To the contrary, our national "experience favors this legislation as the most efficient mode of preventing, with the least inconvenience," the expenditure of insurance funds for treatment that ultimately is determined to be unreasonable or unnecessary. See *Missouri Pac. Ry. Co.*, 115 U.S. at 523.

The nearly uniform practice of over 40 States and the federal government cannot be dismissed as unthinking or arbitrary. Our Nation's democratically elected officials are far better positioned than federal judges — who possess limited expertise and informa-

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[29] The exceptions are North Carolina, where bills over $2,000 need not be paid until after receipt of approval by the Industrial Commission, and Oklahoma, where the Oklahoma Workers' Compensation Court makes case-by-case determinations on payment of disputed bills. S. ECCLESTON & C. YEAGER, *supra*, at 219, 232. Thus, even these exc ptions are more apparent than real.

tion, are less accountable to the people, and whose rulings lack the flexibility to adapt to changing circumstances — to determine fair procedures for resolving insurance claim disputes, the allocation of risk of mistake or fraud, and the efficacy of cost containment strategies. See *Glucksberg*, 117 S. Ct. at 2293 (Souter, J., concurring) ("Not only do [legislatures] have more flexible mechanisms for factfinding than the Judiciary, but their mechanisms include the power to experiment, moving forward and pulling back as facts emerge within their own jurisdictions."). Indeed, given the Third Circuit's conclusion that Pennsylvania workers' compensation law is a "complex and interwoven regulatory web" (Pet. App. 14a), the court should not have substituted its own intuitions regarding the interests of workers, employers, insurers, and health care providers for the considered policy judgment of Pennsylvania's elected officials, and that of virtually every other State in the Union.

CONCLUSION

The judgment of the court of appeals should be reversed. The court of appeals held that the so-called "'unless' clause" of 77 Pa. Stat. Ann. § 531(5) is unconstitutional, and severed it from the remainder of the statute, leaving insurers under the obligation to pay all bills within 30 days even if they are seeking utilization review. Pet. App. 25a. If this Court reverses on the state action and due process questions, or on the due process question alone, that judgment should be reversed in its entirety. If this Court reverses on the state action question without reaching the due process question, the judgment below should be reversed as applied to private insurers and employers, leaving them free to withhold payments during the pendency of utilization review, as permitted under 77 Pa. Stat. Ann. § 531(5).

Respectfully submitted.

ROBERT MCL. BOOTE
BURT M. RUBLIN
Ballard Spahr Andrews & Ingersoll, LLP
1735 Market Street
Philadelphia, PA 19103
(215) 665-8500

Counsel for All Petitioners Except Donegal Mut. Ins. Co.

ROBERT E. KELLY, JR.
Duane, Morris, Heckscher, LLP
305 N. Front Street
Harrisburg, PA 17108
(717) 237-5500

Counsel for Donegal Mut. Ins. Co.

MICHAEL W. MCCONNELL
Counsel of Record
ALAN E. UNTEREINER
STEFFEN N. JOHNSON
SHARON SWINGLE
Mayer, Brown & Platt
190 South La Salle Street
Chicago, IL 60603
(312) 782-0600

Counsel for All Petitioners

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In The

Supreme Court of the United States

October Term, 1998

AMERICAN MANUFACTURERS MUTUAL INSURANCE COMPANY, *et al.*,

Petitioners,

vs.

DELORES SCOTT SULLIVAN, *et al.*,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Third Circuit

BRIEF FOR RESPONDENT SCHOOL DISTRICT OF PHILADELPHIA IN SUPPORT OF PETITIONERS

JAN M. RITCHIE
Counsel of Record
JAMES M. TYLER
PATRICIA FARRELL KERELO
JOSEPH W. CUNNINGHAM
MARK PFEIFFER
SCHUBERT, BELLWOAR, CAHILL & QUINN
Attorneys for Respondent School District of Philadelphia
1500 John F. Kennedy Blvd.
Suite 1400
Philadelphia, PA 19102
(215) 587-0146

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QUESTIONS PRESENTED

1. Whether insurers and self-insured employers become "state actors" for purposes of the Due Process Clause when a state-authorized utilization review procedure is invoked.

2. Whether Sections 306(f.1)(5) and (6) of the Pennsylvania Workers' Compensation Act, 77 Pa. Stat. Ann. '531(5) and (6) (West Supp. 1998), which allow Pennsylvania self-insured employers and Pennsylvania insurers to delay payment of challenged medical treatment pending utilization review to determine the reasonableness and necessity of the specific treatment, comport with Due Process.

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Bello v. Walker, 840 F.2 1124, 1128 (3rd Cir.), *cert. denied*, 488 U.S. 851 (1988)	22
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STATEMENT OF THE CASE

A. Pennsylvania's Compelling Need For Workers' Compensation Reform

Prior to the enactment of cost containment initiatives amending Pennsylvania's Workers' Compensation Act, Act of June 2, 1915, P.L. 736, *as amended*, 77 Pa. Stat. Ann. § 1 et seq. (West Supp. 1998) (hereinafter "Act"), the School District of Philadelphia (hereinafter "School District"), among other Pennsylvania employers, confronted soaring costs of mandatory workers' compensation.[1] The high cost of workers' compensation insurance was crippling, prohibiting industries from competing successfully in Pennsylvania. Pa. Legis. J. - Senate 472 (April 19, 1993). It is indisputable that jobs were lost every day due to workers' compensation costs. Pa. Legis. J. — Senate 1046 (June 16, 1993).

In 1993, prior to the amendments to the Act, the costs to insurers of workers' compensation was approximately $23 million. Pa. Legis. J. — House 18 (March 30, 1993). There were concerns regarding whether the State Workers' Insurance Fund (hereinafter "SWIF") was actuarially sound. Pa. Legis. J. — House 2015 (December 11, 1991). Discussion indicated that SWIF, which insured approximately 450,000 employees working for approximately 35,000 Pennsylvania employers, was on the verge of bankruptcy and operating at a loss. Pa. Legis. J. — Senate 1044-1045 (June 16, 1993); Pa. Legis. J. — Senate 473 (April 19, 1993).

The Commonwealth's General Assembly witnessed the exodus of business. Pennsylvania Bureau of Workers' Compensation, Annual Report, 1996-1997 (hereinafter "Annual Report") at ii; News Brief from the Office of Governor Tom Ridge, Vol. 1, Issue 8 (May 31, 1996); <http.//www.state.pa.us/pa_exec/governor/news_briefs/ Vol1iss8.html>. News Brief from the Office of Governor Tom Ridge, Vol 1, Issue 7 (May 24, 1996). <http.//www.state.pa.us/pa_exec/governor/news — briefs/ Vol1iss7.html>. Other states, including Ohio and West Virginia, were funding efforts to identify Pennsylvania businesses that were disenchanted with the business climate of Pennsylvania and attract these businesses to their respective states. Pa. Legis. J. — House 2019 (December 11, 1991).

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1. The relevant cost containment provisions of the Act of July 2, 1993, P.L. 190, No. 44, appear in Section 306 (f.1) (5) and (6) of the Act, 77 Pa. Stat. Ann. ' 531 (5) and (6) (West Supp. 1998) (hereinafter "Act 44").

Employers who fled the Commonwealth for more business-friendly states attributed the reason for relocation to accelerating economic decline due to workers' compensation losses.[2] Annual Report at ii; News Brief from the Office of Governor Tom Ridge, Vol. 1, Issue 8, (May 31, 1996); <http.//www.state.pa.us/pa_exec/governor/news_briefs/Vol1iss8.html>. News Brief from the Office of Governor Tom Ridge, Vol. 1, Issue 7 (May 24, 1996). <http.//www.state.pa.us/pa_exec/governor/news_briefs/Vol1iss8.html>.

Not surprisingly, the Pennsylvania legislature debated and ultimately passed cost containment initiatives with the express intention of greatly

2. The legislative history of Act 44 is replete with examples of inequities the pre-Act 44 workers' compensation system worked upon Pennsylvania employers and the compelling need for change. For example, Senator Mowery in noting the severity of the workers' compensation problem in Pennsylvania observed that one particular Pennsylvania company reported that it would pay between $275,000 and $330,000 more in insurance premiums in Pennsylvania then it would be required to pay in the surrounding states of New Jersey, Maryland and Virginia. Pa. Legis. J. — Senate 283 (February 10, 1993). Senator Madigan reported that a publishing industry relocated to Kansas because workers' compensation issues were the "straw[s] that broke their back." *Id.* Senator Madigan also reported that 350 union jobs were being lost to the State of Indiana as the result of the high cost of workers' compensation; and that 129 steelworkers' jobs were lost due to workers' compensation costs. *Id.*

One senator, Senator Peterson, reported that he was losing business almost weekly "laying at the feet of workmen's comp." Describing one such business that had recently closed its doors, he stated ". . . 55 people no longer have a job because of a workmen's comp system that is bankrupting the employers of this Commonwealth." Pa. Legis. J. — Senate 472 (April 19, 1993). Senator Peterson urged passage of meaningful reform to remedy the workers' compensation problem to preserve Pennsylvania jobs. *Id.* 472-473.

In the Pennsylvania House of Representatives, Representative Clymer discussed a small manufacturing business employing 15 people. Pa. Legis. J. — House 544 (March 30, 1993). The business cited a 188% increase in workers' compensation over the 5 years proceeding 1993. *Id.* He also reported that Bucks County, Pennsylvania, lost 50 manufacturing jobs to Florida with one of the reasons being inability to deal with workers' compensation. *Id.*

Representative Dent reported 48 jobs were moving from the City of Bethlehem, Pennsylvania, to Camden, New Jersey. *Id.* at 547. He also related that a plant relocated to Virginia and 220 jobs were lost from his district. The only reason publicly stated for the job loss was the fact that Pennsylvania's workers' compensation system was "just atrocious". This business paid nearly $500,000.00 in workers' compensation in Pennsylvania and only $3,000.00 in Virginia. *Id.* at 547.

curtailing the escalating health care costs in the treatment of work-related injuries and disease. Department of Labor and Industry, Workers' Compensation Medical Cost Containment, Pennsylvania Bulletin, (Vol. 24, No. 30, July 23, 1994); Department of Labor and Industry, Bureau of Workers' Compensation, Amendments to the Workers' Compensation Act, Pennsylvania Bulletin, (Vol. 23, No. 35, August 28, 1993). The General Assembly acted to amend the workers' compensation system to more fairly balance the interests of workers injured at work (hereinafter "claimants") and employers in an effort to ensure an affordable compensation system for Pennsylvania. Pa. Legis. J. — House 542 (March 30, 1993), (referencing numerous letters regarding the need for workers' compensation reform); *see also* Pa. Legis. J. — House 1504-1505 (June 24, 1993) (need for governor, insurance department and legislature to act to cap medical costs and prevent rate hike).

In the midst of spirited debate regarding the best way to keep needed business in Pennsylvania, Representative Joseph Gladeck discussed at length the history of Pennsylvania's Workers' Compensation Act. Representative Gladeck addressed the Commonwealth's adoption, in 1972, of the report and recommendations of the National Commission on Workers' Compensation. The recommendations were issued after the enactment of the Federal Occupational Safety and Health Act in 1970. Pa. Legis. J. — House 543 (March 30, 1993). Representative Gladeck explained that this report substantially expanded benefits for claimants. The changes represented a fundamental alteration to the historical compromise underpinning the workers' compensation system. The system stemmed out of an arrangement where employees gave up their right to sue in exchange for being provided a fixed wage loss benefit upon the occurrence of an identifiable accident at work. *Id.*

The expansion of benefits included changes from coverage for accidents to coverage for injuries thus including "soft tissue", repetitive and occupational disease as injuries under the Act; changed wage loss benefits by substantially expanding them and providing for annual adjustment in the maximum amount; and changed the Act to provide unlimited medical coverage. *Id.* After the dramatic change to substantial benefits in 1972, the Commonwealth experienced a growth trend that increased rapidly. By the early 1990's, it was projected that the cost of the expanding workers' compensation program would overwhelm

Pennsylvania's economy, businesses and citizens if not dealt with.[3] *Id.* at 543. As Representative Gladeck pointed out, the changes being discussed, which were ultimately included in Act 44, did nothing to alter the range of the expanded benefits given to claimants' in 1972 and only sought to make those benefits affordable. *Id.*

The Pennsylvania legislature also recognized that the rising costs of the medical aspect of workers' compensation was an avenue of expense that could be controlled. It was noted that $400,000,000 of medical costs were saved in automobile insurance by capping and pro-rating by the insurance department; the federal government capping health care with "DRGs" (diagnostic related grounds); and the "*Blues*" (Blue Cross/ Blue Shield health coverage) capping health care in accordance with the automobile insurance medical cost caps. Pa. Legis. J. — House 2019-2020 (December 11, 1991). The legislative perception was that health care abuse was moving to workers' compensation because it was the only major medical system that was unregulated. *Id.*

Accordingly, it is readily apparent from review of the legislative history of Act 44 that in implementing the cost-containment initiatives, the Pennsylvania legislature intended to balance inequities and provide a system that protects not only claimants but employers in Pennsylvania as well.

B. Statutory Background

The Act establishes a required insurance system to provide compensation to employees who sustain injuries in the course of and related to their employment. It provides the exclusive means by which an employee may recover against employers for work-related injuries. 77 Pa. Stat. Ann. § 481; *Winterberger vs. CNA Ins. Co.*, 72 F.3d 318 (3d Cir. 1995). Compensation under the Act is payable without regard to negligence. 77 Pa. Stat. Ann.§ 431.[4]

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3. Particularly emphasized were the concerns that businesses were not expanding because of high workers' compensation rates; businesses were closing because they could not absorb the costs of workers' compensation; businesses were fleeing the state to surrounding states with more equitable compensation systems; and Pennsylvania citizens were losing jobs and facing unemployment due to the costs. *Id.* at 544.

4. Both wage replacement payments, which are contingent on a continuing wage loss due to a work injury, and payment for reasonable medical services are benefits payable under the Act. 77 P.S. §§ 511-516, 531.

The Act requires employers to either obtain insurance or self-insure liability under the Act. 77 Pa. Stat. Ann. § 501. Employers who do not self-insure may obtain insurance from any insurance carrier authorized to write workers' compensation policies within Pennsylvania, including the State Workman's Insurance Fund ("SWIF"). SWIF was created by the Pennsylvania General Assembly to provide coverage to any employers who request it. 77 Pa. Stat. Ann. § 221, 501. When insured, the insurer merely "assume[s] the employer's liability [t]hereunder and shall be entitled to all of the employer's immunities and protection. . . ." 77 Pa. Stat. Ann. § 501.

Pennsylvania's compensation system is administered by the Department of Labor and Industry, through its Bureau of Workers' Compensation (the "Bureau"). 77 Pa. Stat. Ann. §§ 27, 711. The compensation scheme provides three methods by which an employer pays compensation. The employer may file a Notice of Compensation Payable with the Department of Labor and Industry; enter into an agreement with the injured claimant to pay compensation; or pay pursuant to an order of a Workers' Compensation Judge where an employee's claim petition has been granted. 77 Pa. Stat. Ann. § 731.

Prior to the enactment of the medical cost containment provisions of Act 44 in 1993, and the legislative refinement of the process in 1996 under Act 57, Pennsylvania employers and insurers were required to pay all medical bills that a physician or other licensed practitioner of the healing arts submitted with a report until such time as a workers' compensation referee (later defined "workers' compensation judge") ruled upon any challenge to that treatment. 77 Pa. Stat. Ann. § 531(2)(ii). Employers were required to have a reasonable basis to contest the bills (i.e., a medical opinion that the bills were not reasonable or necessary) before filing petitions to challenge injured employees' entitlement to receipt of the benefits, 77 Pa. Stat. Ann. § 996;[5] and the Act expressly prohibited the workers' compensation referees from granting a supersedeas or stay of the payment of medical bills while a challenge to treatment was pending review. 77 Pa. Stat. Ann. § 531(2)(ii).

If an employer or insurer were to prevail on a review petition, the Supersedeas Fund, created by annual assessments on Pennsylvania

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5. *Werz v. Workmen's Compensation Appeal Board (Dep't. of Corrections)*, 683 A.2d 1287 (Pa. Cmwlth. 1996), *appeal denied*, 690 A.2d 1165 (Pa. 1997). Employers remain obligated to maintain a reasonable contest under Act 44 and 57, as well.

employers and insurers, was available for reimbursement. *Insurance Co. of N. Am. v. Workmen's Compensation Appeal Bd. (Kline & Packard Press)*, 586 A.2d 500 (Pa. Cmwlth. 1991), *aff'd*, 619 A.2d 1356 (Pa. 1993); *Pennsylvania Macaroni Co., Inc. v. Workmen's Compensation Appeal Board*, 387 A.2d 949 (Pa. Cmwlth. 1978). However, the Supersedeas Fund only reimbursed the value of those medical bills (without interest) which were paid after filing a review petition challenging the reasonableness and necessity of treatment. 77 Pa. Stat. Ann. § 531(2)(ii) and 999(a). *See, e.g., Laundry Owners Mut. Liab. Ins. Ass'n. (Stop-N-Go Food Stores) v. Workmen's Compensation Appeal Board (Herpak)*, 617 A.2d 860 (Pa. Cmwlth. 1992), *aff'd*, 644 A.2d 697 (Pa. 1994) (recognizing that medical expenses, but not interest, can be reimbursed by the Supersedeas Fund for payments made pending final outcome of the case).

Repeatedly, employers found that even their own proportionate share of funds paid into the Supersedeas Fund were not fully available to them when extensive unreasonable and unnecessary treatment was rendered prior to the submission of bills to employers.[6] *Laundry Owners Mut. Liab. Ins. Ass'n.* In such situations the most the employer who challenged the bills through a review petition would ultimately be entitled to receive from the fund was the value of any bills paid following the filing of the petition. For example, if unreasonable and unnecessary surgery was performed and enormous bills were submitted, the employer would be forced to pay for that surgery. If ultimately successful on a petition to review medical treatment, the employer would only recoup from the fund the costs of any follow up provided after the employer secured an opinion that the surgery was not reasonable and necessary and then filed a petition with the Bureau.

C. Workers' Compensation Cost Containment Reform

a. 1993 Amendments — Act 44

On July 2, 1993, the Pennsylvania Legislature passed various amendments to the Workers' Compensation Act which were specifically intended to contain the spiralling medical costs associated with work-related injuries. *See also* Department of Labor and Industry, Bureau of

6. Employers and insurers are annually assessed for the Supersedeas Fund pursuant to a formula set forth at 34 Pa. Code 121.23(a). The formula requires the assessment to be 100% of the amount reimbursed to insurers and self-insurers in the proceeding year.

Workers' Compensation, Act 44; Pennsylvania Bulletin, (Vol. 25, No. 45, November 11, 1995). One of these amendments was the creation of the utilization review process, a non-adversarial administrative process which allows for the review of the reasonableness or necessity of medical treatment being received by a claimant. Section 8 of Act 44, renumbered as 306 (f.1) (5) and (6), and amended, 77 Pa. Stat. Ann. § 531 (5) and (6).

Where the utilization review process is invoked, the Act "tolls" the requirement that employers or insurers must pay for medical treatment within 30 days of receipt of the bill by the provider. 77 Pa. Stat. Ann. § 531(5) as further defined in 34 Pa. Code § 127.208. A claimant, employer or insurer may invoke the utilization review process by submitting to the Bureau of Workers' Compensation a request for review of specified treatment on a form prescribed by the Bureau. 34 Pa. Code §§ 127.451, 127.452. The request must be served upon all parties including the claimant, employer, insurance company and medical provider. 34 Pa. Code § 127.452. The Act does not suspend, nor does it require, medical providers to stop providing the challenged treatment to claimants.[7]

7. Physicians are ethically required to continue treatment. The Medical Practice Act of 1985, Act of December 20, 1985, P.L. 457, No. 112, 77 Pa. Stat. Ann. § 422.1 *et seq.* (hereinafter "Medical Practice Act), prohibits unprofessional conduct by physicians. The term "unprofessional conduct" includes "departure from or failing to conform to an ethical or quality standard of a profession." 63 Pa. Stat. Ann.. § 422.41.

The American Medical Association has issued the following ethical guidance concerning continuity of patient care:

> 5. The patient has the right to continuity of healthcare. The physician has an obligation to cooperate in the coordination of medically indicated care with other healthcare providers treating the patient. The physician may not discontinue the treatment of a patient as long as further treatment is medically indicated, without giving the patient reasonable assistance and sufficient opportunity to make alternative arrangements for care.
> 6. The patient has a basic right to have available adequate healthcare. Physicians, along with the rest of society, should continue to work toward this goal. Fulfillment of this right is dependent upon society providing resources so that no patient is deprived of necessary care because of inability to

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A review request is assigned by the Bureau to a utilization review organization ("URO"). 34 Pa. Code §§ 127.403, 127.453(a). Utilization review organizations consist of impartial medical or health care providers authorized by the Secretary of Labor and Industry to conduct utilization reviews.[8] 34 Pa. Code § 127.401(b). All parties and their legal counsel, if known, are advised of the utilization review organization assignment by the Bureau. 34 Pa. Code § 127.453(b). If a utilization review organization cannot perform the review request assigned to it for any reason, it must notify the Bureau and return the request to the Bureau for reassignment. 34 Pa. Code § 127.454. Where the utilization review organization has a conflict of interest, the matter must be reassigned. 34 Pa. Code § 127.455.

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> pay for the care. Physicians should continue their traditional assumption of a part of the responsibility for the medical care of those who cannot afford essential healthcare. Physicians should advocate for patients in dealing with third parties when appropriate.

American Medical Assn., Report of the Council on Ethical and Judicial Affairs, Fundamental Elements of the Patient-Physician Relationship (1994), <http://www.ama-assn.org/ethic/fundelms.htm>.

The Office of General Counsel of the American Medical Association has issued the following guidance with regard to ending patient/physician relationships:

> Once a patient-physician relationship has begun, a physician is generally under both an ethical and legal obligation to provide the services as long as the patient needs them . . . according to the AMA's Council on Ethical and Judicial Affairs, a physician may not discontinue treatment of a patient as long as further treatment is medically indicated, without giving the patient reasonable notice and sufficient opportunity to make alternative arrangements for care. Further, the patient's failure to pay a bill does not end the relationship, as the relationship is based on a fiduciary, rather than a financial responsibility.

American Medical Assn., Office of the General Counsel, Div. of Health Law, Ending the Patient-Physician Relationship (1994), <http://www.ama-assn.org/physlegl/legal/termrel.htm>.

8. Standards for reviewers include the requirement of licensure in the same profession and specialty as the provider under review. For reconsideration, the providers were required to be board-certified in the specialty. All reviewers are also required to maintain an active clinical practice. July 23, 1994 Pennsylvania Bulletin.

If the utilization review organization retains the assignment, it must request the records of the treating providers within 5 days from receipt of the assignment. 34 Pa. Code § 127.457. Only the records of actual treating health care providers (the provider under review and other treating providers) may be obtained by the utilization review organization. 34 Pa. Code §§ 127.459, 127.460. Utilization review organizations may not request and cannot be supplied with reports of independent medical examinations performed at the request of an insurer, employer, claimant or attorney. 34 Pa. Code § 127.461. Although an insurer or employer may initiate the utilization review process, they have no evidentiary input and provide no independent information which may influence or affect the ultimate determination. The utilization review is only based upon the treating providers' records and the discussions, if any, the reviewer has with the provider under review. *Id*; 34 Pa. Code § 127.469. The provider under review must be given the opportunity to discuss the challenged treatment with the reviewer. *Id.*

The reviewer must have the same profession and specialty as the provider under review and shall apply the generally accepted treatment protocols to the case. 34 Pa. Code §§ 127.466, 127.467. The sole issue to be determined by the reviewer is whether the treatment under review is reasonable or necessary for the claimant's medical condition. Causation and "work-relatedness" must be assumed by the reviewer. 34 Pa. Code § 127.470. The "reasonable or necessary" finding must be definite and not advisory. 34 Pa. Code § 127.471. The reviewer is not to decide whether the claimant is disabled, whether maximum medical improvement has been obtained, or comment upon the quality of care or the reasonableness of the fees. 34 Pa. Code § 127.470. Thus, questions of causality remain within the exclusive jurisdiction of workers' compensation judges.

The utilization review organization must complete its review and render its determination within 30 days of a completed utilization request. 34 Pa. Code § 127.465. A "completed" request occurs upon the utilization review organization's receipt of medical records or 35 days from the date of notice of the assignment, whichever is earlier. *Id.*

The utilization review organization advises the claimant of the reviewer's determination and the basis therefore and provides the appropriate forms for claimants to seek further review.

Either the form for reconsideration or a petition for review is served with the determination on all parties and the claimant's attorney, if known. 34 Pa. Code § 127.476.

The reviewer's written report must include a list of records reviewed; documentation of actual or attempted contacts with the provider under review; the findings and conclusions of the reviewer; a detailed rationale for those conclusions, with citations to generally accepted treatment protocols and medical literature as appropriate. 34 Pa. Code § 127.472. Determinations must be explicit and final. If, there is medical doubt in the reviewer's mind, that doubt must resolve in favor of the treating provider. 34 Pa. Code § 127.471(b).

The report must be signed and verified by the reviewer, and then served upon the Bureau and all parties. 34 Pa. Code §§ 127.473, 127.476.

The employer or insurer pays for the initial utilization review regardless of who requested the review or the outcome. 34 Pa. Code § 127.477. If the reviewer determines the treatment is reasonable and necessary, the employer must pay the bill irrespective of its intention to challenge the treatment further on appeal.[9] 34 Pa. Code § 127.208(f).

b. 1996 Amendments — Act 57

Subsequent to the institution of the instant case, the Act was amended. Act of June 24, 1996, P.L. 350, No. 57 (hereinafter "Act 57"), which became effective August 23, 1996, eliminated the reconsideration level of the utilization review process. Prior to Act 57, any party dissatisfied with the outcome of the initial utilization review could file with the Bureau, on one of its prescribed forms, a request for reconsideration. 34 Pa. Code §§ 127.501, 127.502. The reconsideration request had to be filed within thirty days of receipt of the initial utilization review determination. *Id.*

Under pre-Act 57 procedures, the Bureau then forwarded the reconsideration request to the utilization review organization which conducted the initial review. 34 Pa. Code § 127.505. All parties were given notice of the assignment. 34 Pa. Code § 127.505(b). The reconsideration review would then be assigned by the utilization review organization to a reviewer other than the initial reviewer. 34 Pa. Code § 127.509. The reconsideration process then proceeded in a manner substantially similar to the initial utilization review process. 34 Pa. Code §§ 127.503-127.515.

The Bureau would advance the costs of the reconsideration and later bill the "losing party", who was identified applying the criteria enumerated

9. Prior to Act 57, if the challenged treatment was found reasonable or necessary by the initial reviewer, the employer or insurer had to pay the provider's bills unless it requested reconsideration of the decision. 34 Pa. Code § 127.479.

in the regulations. 34 Pa. Code § 127.514(a). However, the payment of the costs imposed was not required before the losing party could file a petition for review before a Workers' Compensation Judge.

Any party dissatisfied with the reconsideration determination could file a petition for review with the Bureau within 30 days of the utilization review organization reconsideration determination. 77 Pa. Stat. Ann. § 531(6)(iv); 34 Pa. Code §§ 127.551-127.556. If the challenged treatment was found to be reasonable or necessary on reconsideration, the employer or insurer was required to pay for it even if a petition for review was filed. 34 Pa. Code § 127.208(f).

c. De Novo Review

Before Act 57's passage, after reconsideration, a dissatisfied party could petition for a de novo hearing before a Workers' Compensation Judge. 34 Pa. Code § 127.551-556. Due to Act 57's elimination of the reconsideration step, a dissatisfied party may now file such a petition directly with the workers' compensation judge from the initial utilization review decision. *Id.*

The petition for review of utilization review determination procedures before the Workers' Compensation Judge are essentially the same now as they were prior to Act 57. The petition is assigned to a Workers' Compensation Judge for a hearing de novo. 34 Pa. Code §§ 127.553-127.556. The judges are appointed by the Secretary of Labor and Industry to hold hearings. 77 Pa. Stat. Ann. § 701 (West Supp. 1998). They are empowered to subpoena witnesses, order the production of documents, and hear evidence on petitions assigned to them. 77 Pa. Stat. Ann. § 833. Judges must base their findings of fact on sufficient, competent evidence. 77 Pa. Stat. Ann. § 834 (West Supp. 1996). In addition to findings of fact, their decisions must contain conclusions of law and a concise explanation of the rationale for the decision reached. *Id.*

If an employee prevails on the petition for review of utilization review decision, the employee is entitled to an award of benefits plus 10% interest. 77 Pa. Stat. Ann. § 717.1(a) (West Supp. 1998)). A claimant may also recover litigation costs. 77 Pa. Stat. Ann. § 996 (West Supp. 1998).

d. Further Appellate Review

Any dissatisfied party may appeal a Workers' Compensation Judge's decision to the Workers' Compensation Appeal Board (hereinafter the "Board"). 77 Pa. Stat. Ann. § 701. The Board reviews the decision for

errors of law and to determine whether findings of fact are supported by substantial evidence. 77 Pa. Stat. Ann. §§ 854-855. The Board's decisions are appealable as of right to the Commonwealth Court of Pennsylvania. 42 Pa. C.S. § 761.

D. The Civil Rights Challenge to Utilization Review

Ten employees claiming entitlement to workers' compensation benefits initiated this civil rights action pursuant to 42 U.S.C. § 1983, challenging the process for reviewing the reasonableness and necessity of medical treatment under the utilization review process enacted in 1993 amending the Act. The Philadelphia Area Project on Occupational Safety and Health, an organization which advocates on behalf of claimants; and the Philadelphia Federation of Teachers, a labor union which represents employees of the Philadelphia School District also were included as Plaintiffs. C.A. App. A74-A120. The claims were brought on behalf of a class of workers' compensation claimants who allege to have had or in the future will have payment for some or all of their medical treatment suspended during the utilization review process that is being challenged.[10] *Id.*

The defendants include various state officials responsible for administering portions of the workers' compensation system, several private insurance carriers which issue workers' compensation policies (Petitioners in this matter hereinafter referred to as "insurers") and the School District. The School District was the sole self-insured defendant named in the class action suit. C.A. App. A74-A120, A163-A196.

The questions presented to this Honorable Court in the order of importance to the Commonwealth of Pennsylvania as a whole are whether the Utilization Review procedures as set forth in the cost containment initiatives of the Pennsylvania workers' compensation act violate the Fourteenth Amendment to the United States Constitution; and whether private insurance companies or self-insured employers become state actors and subject to civil damages for purposes of the due process clause when they elect to use the state-authorized cost containment procedure.

a. District Court Proceedings.

Plaintiffs' original complaint alleged that the 1993 amendments to the Act ("Act 44") violated constitutional due process in allowing for the

10. No class was certified, although Plaintiffs moved the trial court for class certification on May 28, 1996. C.A. App. A12.

suspension of medical benefits without prior notice to the employee and an opportunity to be heard. C.A. App. A164-A196. The Complaint asserted that pursuant to Section 306(f.1)(5) of Act 44, insurers or self-insured employers may seek utilization review of the reasonableness and necessity of medical treatment received by claimants. C.A. App. A174-A175. Plaintiffs alleged that the initiation of the utilization review process operated as an "automatic supersedeas" which allowed the insurers or employers to stop paying for the treatment pending the review. C.A. App. A175.

Plaintiffs asserted that the insurers and School District violated their due process rights by suspending the payment of medical benefits during the pendency of the utilization review process. C.A. App. A179. The Complaint further alleged that the Commonwealth officials also violated Plaintiffs' due process rights by participating in the utilization review process and failing to prohibit insurers from suspending the payment of medical benefits pending review. *Id.*

The insurers and the School District filed motions to dismiss the original Complaint, including the claims of Susan Hansen. C.A. App. A9. In their motion, the insurers argued that invoking the utilization review process did not constitute "state action" as required by Section 1983. The School District moved for dismissal on the grounds that it could not be sued for violations of the Due Process Clause of the Fourteenth Amendment under 42 U.S.C. § 1983 because it did not promulgate any policies or procedures or develop any standard operating practice pertaining to utilization review that could have caused a deprivation of plaintiff Susan Hansen's constitutional rights. The School District argued in its motion that its third party administrator invoked the process and decided to suspend payment, without specific direction from the School District and, therefore, no "state action" was present. C.A. App. A56, A72-A73.

In a May 8, 1995 Order, the District Court granted Plaintiffs' request for discovery on the issue of "state action". C.A. App. A9. After discovery, Plaintiffs filed a motion for partial summary judgment against the insurers and the School District. C.A. App. A10. In a January 24, 1996 Order, the District Court denied Plaintiffs' motion; denied the School District's motion to dismiss; and granted the insurer's motion to dismiss. C.A. App. A48. The Court found that the insurers were not "state actors" and denied the School District's motion, holding that more discovery on the state action issue was warranted. C.A. App. A72-A73. Plaintiffs'

subsequent motion for a final order under Rule 54(b) and motion for reconsideration were denied. C.A. App. A11.

On or about May 21, 1996, Plaintiffs filed an Amended Complaint which added several new parties and claims. C.A. App. A74-A120. Plaintiffs reiterated their due process challenge to the procedures surrounding the suspension of payment of medical benefits during the utilization review process. They also asserted that Act 44 violated substantive and procedural due process in imposing the cost of reconsidering the initial review decision on the losing party. In addition, Plaintiffs claimed that the Commonwealth officials violated procedural due process in failing to promulgate regulations governing Workers' Compensation Judges' adjudication of petitions for review of utilization review decisions. *Id.*

On or about June 20, 1996, the Commonwealth officials filed a motion to dismiss the Amended Complaint. C.A. App. A12-A13. By Order and Memorandum entered November 8, 1996, the District Court granted the Commonwealth officials' motion, determining that the Workers' Compensation Act comports with due process. C.A. App. A17-A44. Based upon this Order and Memorandum, the School District filed a motion for judgment on Plaintiffs' Amended Complaint pursuant to Fed. R.Civ.P. 12(c). C.A. App. A14. By Order dated December 13, 1996 and entered December 16, 1996, the District Court granted the School District's motion. C.A. App. A16. Plaintiffs appealed to the United States Court of Appeals for the Third Circuit.

b. The Proceedings In The Court Of Appeals.

The Third Circuit reversed the District Court's rulings on the insurer's summary judgment motion as well as the Commonwealth's summary judgment motion. Pet. App. 1a-40a. In doing so, the Third Circuit erroneously equated the cost containment feature of the utilization review provisions allowing the tolling of the required time for payment of medical bills under the Act, with a supersedeas on a claimant's entitlement to any or all medical treatment pending review and, thus, violative of the employee's due process rights. The court determined that the claimants were not given adequate notice that their benefits may cease after a utilization review is invoked and were not provided an opportunity for written input to the utilization reviewer prior to the "termination" of benefits taking effect. Pet. App. 21a-25a, 30a-33a.

The Court also found that the private insurance companies were state actors and could be joined in a Section 1983 action when they elect

to delay payment of medical bills pending the utilization review. Pet. App. 12a-19a. The Court remanded for further proceedings including class certification, addressing the issues of whether imposing the costs of reconsideration upon the losing party violates due process and whether the Commonwealth defendants have Eleventh Amendment immunity. Pet. App. 37a.

While the Third Circuit accurately reiterated the procedural posture which led to the School District's dismissal from the case and limited its holding to the state actor issue to the private insurance carriers, it seemed to infer that the School District may no longer contest its status as an alleged state actor. *See* Pet. App. 11a 14, 12a 16, 17a, 37a. It is respectfully submitted that the issues regarding the School District's status as a state actor remain undetermined in this matter consistent with the School District's position before the Third Circuit. School District Brief to Third Cir. n.6. Nevertheless, if the decision of the Court of Appeals is affirmed, in any part, and the case is remanded, issues regarding the School District's status and defenses to the Section 1983 action are preserved and will be addressed at the District Court level.

SUMMARY OF THE ARGUMENT

Pennsylvania's utilization review process accords sufficient due process to Pennsylvania claimants. The cost containment reform measures enacted by the Pennsylvania legislature do not operate to unconstitutionally deprive claimants of compensation benefits. Rather, the reform measures only extend the mandatory time period for payment of medical bills while those bills are reviewed for determination of whether the treatment provided was reasonable and necessary (*i.e.*, compensable under the Act).

Claimants are not unconstitutionally deprived of their benefits during the utilization review process, as the Third Circuit held. Only specifically challenged treatment, as opposed to all medical benefits, is subject to utilization review. Moreover, the process sufficiently balances the competing private interests of claimants and employers in Pennsylvania consistent with the test this Court set forth in *Mathews v. Eldridge*, 424 U.S. 319. The process protects any private interests claimants may have in the uninterrupted receipt of medical benefits because resolution of the compensability of the challenged treatment turns on a medical analysis and determination. During utilization review, all pertinent medical information is provided to the reviewer by the provider. The provider

may also furnish factual information as part of his/her medical records and has an opportunity for an oral consultation with the reviewer. The reviewer is required to follow well-defined procedures in conducting the review to determine only the reasonableness or necessity of the treatment, and the reviewer must be of the same specialty as the provider. Thus, any risk of an erroneous deprivation of medical benefits as a result of the institution of utilization review is slight.

The claimants' interest is further protected because tolling the period in which a bill must be paid in order to submit the bill for review affects neither the claimants' means of living nor their entitlement to other medical treatment from the health care provider subject to review or another health care provider of choice. The statute prohibits the medical provider from collecting any unpaid bills or balance from the Claimant and, the bill(s) must be paid immediately upon circulation of a reviewer's opinion that treatment is reasonable and necessary irrespective of any intentions by the employer or insurer to appeal the reviewer's determination. Full remedies exist which lessen the potential harm to claimants, such as the award of benefits, plus interest, where the claimant prevails on an appeal to a Workers' Compensation Judge.

The significant interests of Pennsylvania employers are protected because the tolling period pending review by the utilization review organization relieves the mandate of payment of unreasonable and unnecessary medical bills. The process, prior to the Third Circuit's *Sullivan* decision in March 1988, proved to be successful. As of February 1, 1997, the Bureau reported a twenty-five percent overall reduction in workers' compensation loss costs. Annual Report at ii. It was reported that the reform which sought to re-establish reasonable costs in a system that was out of control, while still serving the needs of legitimately injured claimants, was producing significant savings for the business community as a whole. Individual self-insured employers saved approximately $48,903,715 in medical compensation when comparing 1993 and 1996 statewide figures. *Id.* at 31.

The total medical compensation payment of insured and self-insured employers decreased 25% or $288 million, between 1993 and 1994 alone. *Id.* In short, the process was working to protect the legitimate governmental interests in containing Pennsylvania workers' compensation costs, preserving Pennsylvania jobs, and ensuring that medical benefits are paid to truly injured employees of the Commonwealth.

With respect to the sufficiency of the notice furnished to the claimants of the review, the process provides claimants with sufficient notice that their treatment is being challenged. Claimants are also provided with notice and an explanation of the appeal process when a determination is made as to the reasonableness and necessity of treatment. The notice provided is sufficient because due process, under the circumstances presented, merely requires that Claimants be notified that their treatment is under review and be provided a meaningful opportunity for hearing on the matter. *Cafeteria Workers v. McElroy*, 307 U.S. 886, 895 (1961) (due process is not a fixed concept with respect to time, place or circumstance).

Because no question is before the reviewer regarding the entitlement of a claimant to medical benefits in general and since a Claimant's entitlement to medical benefits will continue, there is no need for the employer, insurer, or Commonwealth to notify a claimant that medical benefits will be suspended as the Third Circuit held. When the determination is made that the specifically challenged treatment is not appropriate, claimants are notified at that time of the determination and of the proper channels to follow in order to contest the determination. Contrary to the Third Circuit's decision, notice in this case is sufficient, because the claimants are apprised of the review of treatment, the reviewer's determination and the method to secure a meaningful hearing.

The utilization review procedures further provide sufficient opportunity for claimants to participate in a meaningful hearing. Claimants are not deprived of due process because of the lack of an opportunity for either a hearing or an opportunity to submit a statement regarding the treatment prior to the reviewer's determination. Any such statement is neither valuable nor essential to the utilization review process. The doctor is the party to the process whose actions are being reviewed and the doctor, not the claimant, is in a much better position to discuss and persuade the reviewer to find that specific treatment is medically reasonable and necessary. Furthermore, the employer or insurer is precluded from submitting independent medical reports or other documentation to the reviewer. One would surely question the constitutionality of a system which would permit only the claimant and the claimant's doctor to participate, while the employer was precluded from submitting any documentation or provided any opportunity to participation in the utilization review process as it may now exist. Pennsylvania's utilization review system, as currently re-written by the

Third Circuit, works this very injustice. The Third Circuit's "revision" of the Act had a chilling effect on Pennsylvania cost containment initiatives. If this Court does not reverse the Third Circuit's decision, *in toto*, Pennsylvania will be strapped with a compensation system that is simply not workable and in fact, costs Pennsylvania more than the pre-reformed measures. The Act was amended in 1993 to replace the old review system with the utilization review process. Therefore, employers may no longer even petition a Judge directly for review of medical treatment. *See* 77 Pa. Stat. Ann. § 531(6) "[e]xcept in those cases in which a workers' compensation judge asks for an review under Section 420, disputes as to reasonableness and necessity of treatment . . . *shall* be resolved" by utilization review). [emphasis added, citation omitted].

Therefore, Pennsylvania employers and insurers must pay bills without remedy to recoup the funds when those bills are found to be unreasonable or unnecessary. Without a review petition, there is no supersedeas fund reimbursement and recouping the money from doctors or claimants is statutorily prohibited. If this Court rules as to the state actor issue alone, the effect of the Third Circuit's decision is that private employees insured through SWIF, "state actor" employees (including the Commonwealth and other public employers that may ultimately be classified as "state actors"), and private insurers would still be forced to pay the high cost of pre-reform medical expenses without remedy. State actor employers would be precluded from delaying the payment of bills during review and, therefore, lose any chance of avoiding payment for unreasonable and unnecessary treatment. Private employers insured through SWIF will realize those costs directly in their premiums, and private insurers who fund SWIF indirectly will also realize those costs. The providers will no longer have accountability under the Act and the costly abuse that existed prior to Act 44 will return in Pennsylvania.

Finally, as the District Court found, the assessment of a fee upon reconsideration review against a losing claimant does not violate due process. Plaintiffs' interest in uninterrupted workers' compensation benefits does not rise to the level of a "fundamental" right and employees have an alternative to judicial remedies which are not conditioned on the payment of fees. Claimants were simply not denied access to reconsideration, a Workers' Compensation Judge, or the appellate courts as a result of the subject reconsideration fee. See C.A. App. A156; 34 Pa. Code § 127.514(a).

Accordingly, the claims that the utilization review process does not comply with due process were properly dismissed by the District Court and the Third Circuit's decision should be reversed. The decisions of the District Court should be reinstated.

ARGUMENT

I. SELF-INSURED EMPLOYERS, LIKE PRIVATE INSURANCE COMPANIES, DO NOT BECOME STATE ACTORS WHEN THEY ELECT TO USE STATE AUTHORIZED UTILIZATION REVIEW PROCEDURES OR WITHHOLD PAYMENT TO HEALTH CARE PROVIDERS.

Self-insured employers, like private insurance companies, do not become "state actors" when utilization review is initiated and the payment of bills to health care providers is delayed pending a review of reasonableness and necessity of the treatment. *Blum v. Yaretsky*, 557 U.S. 991, 1007-1110 (1982) (state regulation of nursing homes does not convert actions of the homes into state action for purposes of due process); *Jackson v. Metropolitan Edison Co.*, 419 U.S. 345, 350 (1974) (state regulation of public utilities does not convert the actions of the public utilities into state action for due process purposes). The Third Circuit erred in holding that state action is involved when private insurers decide to toll payments to medical providers for treatment pending utilization review.

The School District will not repeat the arguments in support of reversing the Third Circuit and affirming the decision of the District Court on the state actor issue fully and articulately addressed in the insurers' brief. However, it must be stressed that the identified compelling need for containment initiatives pertains equally to self-insured employers (both governmental and private) and private insurers in Pennsylvania. Likewise, the benefits and procedures contained in the utilization review process apply equally to Pennsylvania insurers and self-insured employers, whether governmental or private in nature. 77 Pa. Stat. Ann. § 5531 (5-6).

It is imperative that even if this Court decides that insurers and private self-insured employers are not state actors and that Summary Judgment should have been granted in the instant case, the Court must reach the issue of whether the Act, *as amended*, comports with the Fourteenth Amendment due process requirements. SWIF insures thousands of private employers in Pennsylvania. If this Court does not reach the due

process issue, not only will public employers be effected but the private employers insured through SWIF will be denied access to the cost containment benefit of utilization review. *See* Pa. Legis. J. — Senate 1044-1045 (approximately 450,000 employees working for approximately 35,000 employers were insured through SWIF).

The consequences will be that these entities will be forced to pay bills for treatment that may not be compensable with absolutely no remedy or ability to recoup the value of these costs. The hardship on Pennsylvania employers is great and weighs heavily, considering the stated governmental interest in containing costs which prompted Pennsylvania workers' compensation reform to stop the exodus of jobs to other states. This issue should not be passed over by this Court.

II. THE UTILIZATION REVIEW PROCESS IN PENNSYLVANIA'S WORKERS' COMPENSATION SYSTEM COMPORTS WITH CONSTITUTIONAL DUE PROCESS.

A. Claimants failed to establish a governmental deprivation of a constitutionally protected right.

Rights secured by the constitution are generally protected only against infringement by government. *Lugar v. Edmonson Oil Co.*, 457 U.S. 992, 936 (1982). To trigger the Fourteenth Amendment's procedural protection regarding the due process rights, an individual must have suffered a deprivation of a protected property interest by the government or a private entity deemed to be a state actor. *Id.*

The remedy for a deprivation of a right secured by the Constitution and laws of the United States is provided under Title 42 U.S.C. § 1983. To bring a claim under Section 1983, a plaintiff must establish that he or she was deprived of a federally-protected right and that the conduct allegedly causing the deprivation can be fairly attributable to the State. *See Lugar* at 937 (1982). A Section 1983 plaintiff must also prove that it was the defendant who subjected him or her to the alleged deprivation or otherwise caused the deprivation. *Collins v. City of Harker Heights*, 503 U.S. 115 (1992).

Even if self-insured employers or private insurers are determined to be state actors, Plaintiffs simply have not established the requisite deprivation of a constitutionally protected right during the utilization review process. Pennsylvania claimants are simply not denied treatment at the hands of the employers, insurers or even the Commonwealth during the utilization review process. The decision whether to continue

specifically challenged treatment is left to the treating physician. As the record shows, some physicians continue treatment while others do not.[11] C.A. App. A99, A100, A107, A108-A109, A113. Because tolling payment is not the equivalent of ceasing treatment, the Circuit Court erred in defining and weighing claimants' interest under the *Mathews* test.

The Plaintiffs' challenge to invocation of utilization review by the employer or insurer pertains only to the payment of bills for treatment already provided. Thus, any choice to discontinue ongoing treatment during the review would rest with the treating physician. This provision operates to keep the treating physicians accountable and presumably, if the provider truly believes the treatment is appropriate, treatment will continued. *See*, *Pennsylvania Medical Practice Act*, 77 Pa. Stat. Ann. § 422.1, *et. seq.*; American Medical Ass'n. Report on Ethics, *infra*, n7.

The process does not "suspend" the Plaintiffs' right to all medical benefits as the Third Circuit indicated. Rather, the regulations only allow the employer to toll payment of specific bills for a limited time frame while the bills are subject to utilization review. 34 Pa. Code § 127.208. The regulations direct the employer or insurer to pay those bills if it is determined that the bills are compensable under the Act irrespective of any intentions to challenge further by way of reconsideration review before the Workers' Compensation Judge or appeals to the Workers' Compensation Appeal Board or appellate courts. 34 Pa. Code § 127.208(f). Consequently, where treatment is found to be reasonable and necessary, no suspension or deprivation of benefits takes place at all.[12]

It is when the reviewer determines that the bills pertain to treatment that is not reasonable or necessary that an opportunity for a limited suspension of benefits arises. However, at that juncture, claimants are

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11. As the Commonwealth pointed out in its brief to the Third Circuit, the second private interest is present even when SWIF is the insurer. Although SWIF is created by statute and operated by the State, it insures private employers who pay for the coverage provided. 77 Pa. Stat. Ann. §§ 2221, 241, 283, 301 (West Supp. 1992).

12. Consideration must be given to the Legislative power to se the reasonable time frames during which bills must be paid. The Pennsylvania Legislature could have merely extended the time to pay medical bills to ninety days, allowing time for utilization review. However, then payment of unchallenged treatment could have been delayed and no parties interest would have been served. therefore, the extension of the time period to pay bills pending review is sensible and serves both the interests of claimants and employers.

provided notice that the treatment is not reasonable or necessary and an opportunity for a hearing. 34 Pa. Code § 127.472. Specifically, the reviewer's decision is required to explain the basis for his/her opinion that the treatment has been determined to be unreasonable and unnecessary. *Id.* The review organization must also provide forms for petitioning for further review or reconsideration in pre-Act 57 matters.[13] 34 Pa. Code § 127-476. At the hearing, claimants have an opportunity to present evidence and cross-examine witnesses in order to attempt to have the payments for specific treatment reinstated. Following a workers' compensation judge's decision, the parties have a right to full administrative and judicial review by the Workers' Compensation Appeal Board and Commonwealth Court of Pennsylvania. 77 Pa. Stat. Ann. §§ 531(6)(iv), 701, 42 Pa. CS § 751.

As this Court recognized, constitutionally adequate process is afforded by statutes when reasonable remedies exist to correct errors of administrative bodies in determining rights regarding protected interest. *Bello v. Walker*, 840 F.2 1124, 1128 (3rd Cir.), *cert denied*, 488 U.S. 851 (1988) (the provisions of subsequent process to challenge the denial of a building permit satisfy due process). It is submitted that the utilization review process is adequate, especially in light of the immediate right to review of the utilization reviewer's determination and the remedies available under the Act if payment for treatment is ultimately reinstated. 34 Pa. Code §§ 127.501, 127.502.

B. The Process Provides Claimants Sufficient Notice

Contrary to the Third Circuit's misperception of the utilization review process, any alleged governmental deprivation or termination of medical benefits does not occur as a result of invocation of utilization review. It is not until after the utilization review process is invoked and the utilization review determination is rendered, where employers are entitled to a limited suspension of benefits. *See* 77 Pa. Stat. Ann. 531(6); 34 Pa. Code § 127.208. Thus, the process provides claimants with sufficient meaningful notice during review to keep them apprised of the challenge to treatment and an opportunity for hearing as of the time of the suspension. *See* 34 Pa. Code § 127.208 (mandatory time to pay bills is tolled when submitted to utilization review, and employers are entitled

13. Pre Act 57, claimants had an opportunity to state their position regarding treatment on the petition for reconsideration. Claimants could indicate on the form why they believe the treatment is reasonable and necessary.

to continue a suspension of benefits for the limited treatment upon a determination of unreasonable or unnecessary care).

Specifically, the claimants are notified that the employers or insurers have invoked the utilization review process pursuant to 34 Pa. Code § 127.452 to specifically request review of the reasonableness and necessity of care. *See* C.A. App. B34. The claimant and employer also receive a notice of assignment of utilization review. C.A. App. B35. The notice of assignment again informs the claimant that the reasonableness and necessity of specific medical treatment is being reviewed and that the medical provider must send relevant medical records within thirty days. 34 Pa. Code § 127.453(b).

The Third Circuit states that this notice is not sufficient because the employee is not told that his medical benefits may cease pending review. However, again, at no time during the utilization review process is any factfinder empowered to make determinations as to the causal connection between the treatment and the work injury; whether a claimant has achieved maximum medical improvement; or whether entitlement to medical benefits should otherwise continue. 34 Pa. Code §§ 127.470, 127.471. Because claimants' general entitlement to medical benefits is never at issue, the claimants' right to medical benefits are not "terminated" during review and the notice provided to the claimants need not indicate that benefits may "cease" as the Third Circuit required.

Because claimants' entitlement to medical benefits, generally, continues during utilization review, and it is the treating physicians who will know if they are practicing outside ordinarily accepted protocol, it will be the treating physician who, based upon their own personal knowledge, will decide whether to continue treatment. Of course, the physicians remain free to initiate any other type of treatment or methods of treatment that are more appropriate in order to continue being paid for services. Additionally, nothing in the Act prohibits the claimants from directly paying the doctors for services after it is finally adjudicated that services are outside the parameters of the Act.

The Third Circuit also took issue with the initial request for utilization review and notification of assignment to a utilization review organization as not providing sufficient information or explanation concerning what the utilization review process involves for claimants to understand and participate in the process. Pet. App. 21a-25a. Nevertheless, the initial requests for utilization review and initial assignment notifications provide sufficient notice to the claimants of the challenge to their treatment.

Mullane v. Central Hanover Bank and Trust Co., 339 U.S. 306 (1950) (notice need only apprise interested parties of the pendency of an action and afford them an opportunity to participate at a meaningful time). Because there is no meaningful input which claimants could provide at that juncture in the review process, this notice is sufficient.

The determination will be made by a reviewer upon consideration of medical records and any information provided by the provider (whose payment hinges upon his cooperation) with respect to how the treatment helps a claimant. The provider is the best source for this information and is provided the opportunity to submit records, talk to the reviewer, and persuade the reviewer of the medical basis or bases for a determination that the treatment is reasonable and necessary. Since the payments are issued to the provider, not the claimant, a provider treating within acceptable parameters has a financial incentive to comply in order to secure payment of his/her bills. One must question the appropriateness of treatment by a provider who simply does not comply with the reviewer's request for information.

Moreover, the Third Circuit's determination that the notice was insufficient turned primarily on the decision on the United States District Court for the Eastern District of Pennsylvania in the case of *Baksalary v. Smith*, 579 F. Supp. 218 (E.D. Pa. 1984), *aff'd*, 772 F.2d 893 (3d Cir. 1985), *cert. denied*, 469 U.S. 1146 (1985). However, not only was that decision erroneously decided by the District Court and its holding should be overruled by this Court, that process is inapposite to the one presented here.[14]

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14. In *Baksalary*, a challenge to a portion of former Section 413(a) of the Workers' Compensation Act was addressed, which allowed an automatic supersedeas of all workers' compensation benefit payments under the Act. The supersedeas was "automatic" upon the filing of a petition to terminate benefits that alleged either the employee returned to work at the same or greater rate of pay, or that the employee had completely recovered from his work-related injuries. *Baksalary*, 579 F. Supp. at 221. To obtain a supersedeas on the latter ground, the petition had to be filed within 15 days of an examination, and a physician's affidavit addressing the recovery was required to be attached. *Id.* The supersedeas remained in effect until the termination petition was fully litigated.

The *Baksalary* Court ruled that Section 413(a) violated due process in that a claimant was not given notice of the supersedeas nor an opportunity to respond to the physician's affidavit. *Id.* at 232-33. The concurring opinion (Cont'd)

In *Baksalary*, the District Court determined that when a self-insured employer or insurance company terminated a claimant's benefits based upon a doctor's opinion establishing that payment of compensation is longer warranted, and merely notified the state of that action, the insurer or employer became a state actor and the claimant's constitutionally protected property interest in the workers' compensation indemnity benefits was violated under the Fourteenth Amendment to the United States Constitution. The *Baksalary* holding has been rejected by the Fifth Circuit in *Barns v. Lehman*, 861 F.2d 1383 (5th Cir. 1988). In that decision, the Fifth Circuit explicitly declined to "embrace the reasoning of *Baksalary*" holding that "procedural regulations simply do not suffice to establish the degree of joint participation required to convert private action into state action." 861 F.2d 1387. Similar procedures allowing for termination of benefits based solely upon a doctor's report expressing

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(Cont'd)

concluded that due process was violated by insufficient notice and the insufficient guarantee of decision maker impartiality. *Id.* at 236-237.

Nevertheless, the Third Circuit's reliance on *Baksalary* in this case was misplaced. *Baksalary* involved a provision wholly distinguishable from the provision challenged in the instant case. The concerns which lead to the invalidation of Section 413(a) in *Baksalary* do not exist here. The utilization review process significantly narrower and contains "checks and balances" which afford greater due process protection than the former Section 413(a). The scope and nature of the current provisions ensure impartiality and integrity of the "reasonable or necessary" determination.

First, the only benefits subject to utilization review and possible suspension of payment relate to specific medical treatment. 34 Pa. Code §§ 127.401, 127.402. Other medical utilization benefits and wage replacement benefits are not subject to utilization review or possible suspension under the subject provisions. Under the former Section 413(a), all benefits, including wage benefits, which often provide the employee's sole means of subsistence, were subject to the automatic supersedeas.

Furthermore, the automatic supersedeas under Section 4139a) remained in effect until the matter was fully litigated. Prior to Act 57, if a decision in favor of the treatment was made at the initial review, payment of benefits was required unless the insure or employer sought reconsideration. 34 Pa. Code § 127.208. If the insurer or employer lost again on reconsideration, payment was required regardless of whether further review was sought. *Id.* Act 57, which eliminated the reconsideration process, requires payment to be made if the treatment is upheld at the initial review regardless of whether a petition for review is filed.

an opinion that benefits were no longer compensable were also adopted by the Fourth Circuit in the case *Fleming v. Workers' Compensation Commission of the Commonwealth of Virginia*, 878 F.2d 852 (E.D. Va. 1995), *aff'd mem.*, 78 F.3d 578, *reported in full*, 1996 U.S. App. LEXIS 3858 (4th Cir. Mar. 5, 1996).

In the *Fleming* case, the Fourth Circuit recognized that Virginia law permitted insurers to suspend payment of benefits immediately upon filing an application with the state challenging the entitlement to benefits. The Court recognized that the ultimate decision to stop payment of benefits rested with the insurer who was not a state actor and simply complied with the procedures and exercised its options in compliance with the state's statute.

In the matter sub judice, benefit entitlement is not at issue as it was in *Baksalary*. Moreover, claimants receive sufficient notice of the status of the review at meaningful times and the notifications provide claimants sufficient information with respect to how and when they can participate in a meaningful way. Thus, due process requirements are satisfied.

There is no reason why the employer or insurer should have to pay for treatment that is not reasonable or necessary once the reviewer determines the treatment is outside accepted protocol. The post-review determination hearings provide satisfactory safeguards against erroneous deprivation.

C. Utilization Review Procedures Satisfy Due Process

It is axiomatic that the concept of due process is flexible, focused on ensuring "fundamental fairness" in decision making. *Walters v. National Ass'n of Radiation Survivors*, 473 U.S. 305, 320 (1985). Not being a technical concept, due process is not fixed with respect to time, place or circumstance. *Cafeteria Workers v. McElroy*, 367 U.S. 886, 895 (1961).

> Procedural due process imposes constraints on governmental decisions which deprive individuals of "liberty" or "property" interests within the meaning of the Due Process Clause of the Fifth or Fourteenth Amendment.

Mathews v. Eldridge, 424 U.S. 319, 331 (1976).

The process required varies depending on the nature of the interests at issue and the circumstances under which deprivation may occur. *Walters* at 320; *Morrisey v. Brewer*, 408 U.S. 471, 481 (1972). Nevertheless, "legislatures are to be allowed considerable leeway to

formulate such processes without being forced to conform to a rigid constitutional code of procedural necessities." *Walters*, at 326.

Whether specific procedures satisfy due process is a legal question for the Court to resolve. *Midnight Sessions, Ltd. v. City of Philadelphia*, 945 F.2d 667, 684 (3d Cir. 1991) *cert. denied*, 503 U.S. 54 (1992). In conducting a due process inquiry, Courts must balance three factors: (1) the private interests that will be affected by the official action; (2) the risk that the procedures will result in an erroneous deprivation of the interest and the probable value of additional procedures; and, (3) the governmental interest, including the function involved and the fiscal and administrative burdens that the additional or substitute procedural requirement would entail. *Mathews*, 424 U.S. at 334-335. Applying these factors herein, it is evident that the Pennsylvania legislature enacted an administrative scheme which provides sufficient due process to workers' compensation claimants.

a. Private Interests

Unlike the circumstances presented in *Mathews*, where only one private interest was at issue, the instant case involves two opposing private interests. The District Court correctly defined the private interest of plaintiffs herein as their "desire for uninterrupted receipt of [medical] benefit[s] pending the final administrative decision on their cases." C.A. App. A29. This "interest" is tempered by the fact that Pennsylvania's Workers' Compensation law entitles claimants to retroactive relief, interest and costs if challenged medical treatment is ultimately found, in later proceedings, to be reasonable and necessary. 77 Pa. Stat. Ann. § 717.1, 996; *see also Mathews* at 340; *Cryder v. Oxendine*, 24 F.3d 175, 178 (11th Cir. 1994) (holding that the potential harm to the individual employee is less under Georgia's workers' compensation act, because of the availability of full retroactive relief).

Additionally, eligibility for workers' compensation medical benefits is not based upon financial need and will not deprive the plaintiffs of their means to live as was the case in *Mathews*. As the District Court found, claimant's interests in uninterrupted payment of medical bills is, therefore, further tempered by the fact that claimants have access to additional financial resources such as wage replacement monies or other sources. "[C]laimants may have support from many other sources, 'such as earnings from other family members, workmen's compensation awards, tort claim awards, savings, private insurance, public or private

pensions, veteran benefits, food stamps, public assistance . . .' ". C.A. App. A29, (citing *Mathews*, 424 at 341-342). In fact, while the Act prohibits a doctor from billing an employee directly, nothing in the statute indicates that a claimant is prohibited from reimbursing the medical provider at the end of the administrative process if, in fact, the bills are for services that are found to be outside the compensability provided for in the Act. C.A. App. A30 n4.

Although the Third Circuit cited *Mathews* for the proposition that the interest claimants have is in the uninterrupted receipt of medical benefits, in its analysis, the Third Circuit actually applied the following interest: "interest in the relief that the medical treatment provides to the injured Employees." Pet. App. at 36A. The Third Circuit's abandonment of the *Mathews* analysis is evident from the Circuit Court's criticism that the District Court mischaracterized the nature of claimants' interests. The Circuit Court observed that the District Court viewed these interests as a pecuniary in nature and not interests in the relief that the medical treatment provides. Thus, the Third Circuit actually shifted the focus of the interest to be weighed and expanded the very nature of the benefits Pennsylvania claimants are entitled to receive. The Act does not guarantee all claimants the unqualified right to any treatment they wish with whatever frequency they desire for the duration they choose. Rather, the Act allows only for the payment of reasonable and necessary medical treatment causally related to the work injury.

On the other hand, it cannot be ignored that private insurers and employers have an equally significant interest in not paying for medical treatment that is unreasonable or unnecessary. The Third Circuit completely ignored, without comment, the argument that it must also weigh the interests of insurers and self-insured employers (both governmental and private) in determining and weighing the interests at stake. This second interest is heightened by the inability to recoup any payments for treatment ultimately found to have been neither reasonable or necessary. *See Moats v. Workmen's Compensation Appeal Board*, 588 A.2d 116, 118 (Pa. Cmwlth. 1991). Insurers may only seek to recover from the Supersedeas Fund, which insurers fund themselves and which does not pay interest. 77 Pa. Stat. Ann. § 999; *Liberty Mut. Liab. Ins. Assoc. v. Workmen's Compensation Appeal Board*, 537 Pa. 367, 644 A.2d 697 (1994).

In short, the procedures in place adequately protect the interest of claimants. It is also indisputable that the employers' interests are

heightened and are not tempered by the same type of protection and relief the procedures otherwise afford claimants. It is respectfully submitted that adequate procedural protections are provided by the utilization review process to protect the interests of the plaintiffs against any risk of erroneous deprivation. Because the plaintiffs are granted post review relief and remedies, their interests pale in comparison to the heightened interests that employers and insurers have in not making payments for unreasonable and unnecessary treatment.

b. Risk of Erroneous Deprivation and Alternate Procedures Would Be of No Value

The risk of erroneous deprivation is slight when considering the utilization review system and procedures in place in the workers' compensation system as a whole. The process of utilization review contains numerous "checks and balances" protecting against arbitrary analyses and decisions.

None of the parties, including the insurer or employer, select the reviewer. This provision safeguards the impartiality of the process. 34 Pa. Code § 127.466.

Further securing the integrity of the review determination, the process requires the utilization review organization to assign the utilization request to a reviewer in the same profession and having the same specialty as the medical provider under review. 34 Pa. Code § 127.466. Reviewers are required to apply generally accepted treatment protocol to the case 34 Pa. Code § 127.467. These protocols are to be applied by reviewers in determining "whether the treatment under review is reasonable or necessary for the medical condition of the employee." 34 Pa. Code § 127.470(a). Reviewers must assume that the injuries are work-related, and are prohibited from addressing issues such as current disability status, quality of care, fee reasonableness or whether maximum medical improvement has occurred. 34 Pa. Code § 127.470(b).[15]

15. The provisions on the authorization of utilization review organizations are intensive, ensuring the impartiality of the qualified reviewers utilized and the integrity of the utilization review process. *See* 34 Pa. Code §§ 127.651-670. The Bureau retains the power to suspend the assignment of new reviews to a utilization review organization not performing its responsibilities under the Act, and may revoke a utilization review organization's authority to perform reviews. 34 Pa. Code §§ 127.668, 127.669. The close monitoring of utilization review organizations is another example of the protections which reduce the risk of an erroneous deprivation.

The risk of erroneous deprivation is further minimized because the "reasonable or necessary" decision is a medical determination based upon unbiased medical reports. The Supreme Court has classified medical reports as "routine, standard and unbiased", containing "reliability and probative worth" without the "specter of questionable credibility and veracity". *Richardson v. Perales*, 402 U.S. 389, 407 (1971); *see also Mathews* at 344. In rendering a utilization review decision, the reviewer consults with the provider under review, considers the records and reports of said provider and possibly other treating providers. 34 Pa. Code §§ 127.459, 127.460, 127.469. The veracity of such materials confirms that sufficient due process is provided.

The above described limitations imposed upon reviewers under the Act reflect protection against erroneous decisions beyond those provided in the statutory Social Security disability scheme upheld in *Mathews*. In *Mathews*, the government could terminate disability benefits based solely upon the report of its own independent medical examiner, as opposed to reports by the claimant's treating physician. Pennsylvania's scheme, in contrast, prohibits a utilization review organization from obtaining, and/or a reviewer from reviewing, reports of independent medical examinations. 34 Pa. Code § 127.461 (limiting the scope of records that can be reviewed to records of actual treating health care providers).

Stated another way, unlike the government in *Mathews*, Pennsylvania insurers or employers cannot impact the ultimate outcome of a utilization review. The challenged procedures are non-adversarial and are based solely on a claimant's "side of the story". The utilization procedures provide more due process protection than the scheme upheld in *Mathews*.

The same conclusion is reached upon an examination of *Parham v. J.R.*, 442 U.S. 584 (1979). In *Parham*, this Court reviewed for due process compliance, the State of Georgia's procedures for the voluntary commitment to state mental institutions of children by their parents. Georgia state law empowered the superintendent of the subject institution to assess the child's mental state and determine whether hospital care would likely benefit the child. *Id.* at 605. The state procedures did not provide for a formalized factfinding, judicial or administrative hearing at any stage.

This Court upheld the state procedures. In rejecting the argument that due process required a hearing, the Court emphasized that due process was satisfied where a staff physician, acting independently and utilizing traditional medical techniques, rendered decisions on treatment. *Id.* at

607. The Court, in emphasizing the medical nature of the decision in that case, noted that "[n]ot every determination by state officers can be made most effectively by use of 'the procedural tools of judicial or administrative decision making.' " *Id* at 608 (*quoting Board of Curators of Univ. of Missouri v. Horowitz*, 435 U.S. 78, 90 (1978)).

The process challenged in the instant case is similar to *Parham* in that both cases involve a medical determination. The Pennsylvania process contains subsequent procedures involving petitions for a hearing de novo before a Workers' Compensation Judge where treatment is found to be unreasonable and unnecessary and appeals to the appellate courts of Pennsylvania, as of right, if the claimant is dissatisfied with the results of the de novo hearing. 42 Pa. C.S. § 761. The Court in *Parham* held that the Georgia scheme comported with due process, despite lacking similar subsequent procedures to correct an erroneous decision.

The Third Circuit found that the risk of an erroneous deprivation was great because claimants did not have an opportunity to submit a statement indicating, subjectively, how the treatment helps them. However, any relief or benefit treatment provided a claimant would be documented in the doctor's records and the doctor is given an opportunity to discuss the treatment with the reviewer. Since medical reports are unbiased, objective and trustworthy, problems associated with the credibility of witnesses are not present. *See Matthews*. Therefore, an opportunity for a hearing or written submission by a claimant as to how they believe the treatment helps, would not aid in avoiding erroneous decisions and would be of no value. *See, Parham; Horowitz*.

Plaintiffs suggest that an erroneous deprivation may occur due to the complete or partial non-responsiveness of a provider under review acting counter to a claimant's interests. However, they fail to support this contention with anything other than their broad suppositions. The record is devoid of any averments to support the scenarios claimed in their brief and demonstrate a "risk" of an erroneous deprivation. The slight chance that an erroneous decision may occur under unsubstantiated circumstances is an insufficient ground upon which to find process unconstitutional. Procedural due process rules "are shaped by the risk of error inherent in the truthfinding process as applied to the generality of cases, not the rare exceptions." *Mathews* at 344. This slight risk is tempered by the subsequent procedures provided for review de novo through which any errors can be rectified.

In short, the current provisions provide sufficient due process protection against the risk of erroneous deprivation of specific medical benefits pending utilization review. Under *Mathews*, due process does not require hearing prior to the insurer/employer's suspension of payment of the challenged treatment.

c. Governmental Interest

Under *Mathews*, the governmental interest involved must be factored into the due process analysis. The Commonwealth of Pennsylvania has an interest in ensuring that the payment of medical benefits occurs for only truly disabled employees. This interest is protected by the establishment of a fair and efficient workers' compensation system. The public shares in this interest, because when Pennsylvania insurers or self-insureds pay for unreasonable or unnecessary medical treatment, these costs are passed to the Pennsylvania consumer.

The government also has an interest in containing the medical costs in workers' compensation. Cost-containment reduces, among other things, insurance premiums in the Commonwealth which increases the likelihood that employers and insurers will remain in business in Pennsylvania.[16] Adding an evidentiary hearing to the utilization review process would only increase costs and frustrate the governmental interests.

d. The Interest Balance Weighs in Favor of the Sufficiency of the Utilization Review Process

In assessing what process is due, substantial weight should be accorded to the good faith judgment of the Pennsylvania Legislature and those individuals the Legislature have charged to administer the Workers' Compensation system and the procedures they developed to assure fair consideration of the reasonableness and necessity of medical treatment provided to claimant. *See Mathews* at 348 (affording Congress and those charged thereby substantial weight in their good faith judgments in providing the Social Security Claims entitlement procedures). Substantial

16. The remarks made in the Senate during the debate over whether to adopt Senate Bill No. 1 (later Act 44) reveal that concerns over employers fleeing Pennsylvania's high workers' compensation costs fueled the drive towards the legislation. Senator Madigan, who spearheaded the passage of the bill, expressed the legislature's task as seeking to "achieve a public policy that will encourage employers and jobs to stay in this Commonwealth." Pa. Legis. J. — Senate 284 (February 10, 1993).

weight should be given in light of the fact that the procedures not only provide claimant with protection against erroneous decisions regarding their treatment, they also assure a right to an evidentiary hearing and subsequent judicial review before a denial of a claim becomes final. *Id.*; *see Boddie vs. Connecticut*, 401 U.S. 371, 378 (1971).

The utilization review system sufficiently strikes the necessary balance of protecting the significant interests of the government, employers and private insurers while also protecting the private interest of claimants. Therefore, the utilization review process is constitutionally sound.

D. Imposing reconsideration costs upon the losing party does not violate due process.

Plaintiffs also challenged the constitutionality of the imposition of reconsideration costs under Act 44. The District Court properly rejected Plaintiffs' contention that this provision contravened due process.

Due process is not contravened because the instant case does not involve any fundamental right or interest similar or analogous to those in cases where this Court held that the imposition of fees amounted to a denial of constitutional due process. In *Boddie*, welfare recipients challenged certain Connecticut procedures, including those requiring the payment of filing fees and costs, as a violation of due process. The plaintiffs, claiming indigence, asserted that the filing fees unduly restricted their access to the courts. The Court held that a state could not, consistent with due process, pre-empt the right to dissolve a marriage "without affording all citizens access to the means it has prescribed for doing so." *Id.* at 382-383. The Court reasoned that because the state required its citizens to resort to the state judicial process as "the exclusive precondition to the adjustment of a fundamental human relationship," mandatory court filing fees which precluded indigent access were violative of due process. *Id.* This Court thus recognized one's right to determine marital status as fundamental.

Similarly, in *Little v. Streater*, 452 U.S. 1 (1981), this Court held that the imposition of the cost of blood tests on an indigent party contesting a paternity action was violative of due process. The Court recognized the "constitutionally significant" interest the petitioner had in contesting paternity. *Id.* at 13, 16, n.12. *Little* recognized and protected the individual interest in parental status.

In the instant case, Plaintiffs' desire for uninterrupted receipt of medical benefits does not rise to the level of the interests recognized in

Boddie and *Little*. Instead, Plaintiffs' interest is comparable to the interests of the respective plaintiffs in *United States v. Kras*, 409 U.S. 434 (1973) and *Ortwein v. Scwab*, 410 U.S. 656 (1973). In these cases, the Supreme Court determined that no fundamental right was at issue and upheld the challenged filing fee provisions.

In *Kras*, the Supreme Court upheld statutorily imposed bankruptcy filing fees against a claim brought by an indigent, who alleged that the fee requirement violated their right to constitutional due process. Applying *Boddie*, this Court stated that one's interest in a bankruptcy discharge "does not rise to the same constitutional level" as one's inability to dissolve a marital relationship through the state-mandated judicial process. *Kras* at 445.

In *Ortwein*, the Supreme Court upheld the Oregon appellate filing fee applied to an indigent seeking to appeal an adverse welfare decision. In rejecting petitioners' due process argument, the Court declared that petitioners' interest in increased welfare payments "has far less constitutional significance than the interest of the *Boddie* appellants." *Ortwein* at 659.

The interests of Plaintiffs herein "was far less constitutionally significant than the interest of the *Boddie* appellants." *Id.* While important, the desire for uninterrupted medical benefits is not a fundamental right. *See School Dist. of San Antonio v. Rodriguez*, 411 U.S. 1, 33 (1973) (limiting "fundamental" rights to those explicitly or implicitly guaranteed by the Constitution). Plaintiffs' interest is more akin to those interests in *Kras* and *Ortwein*, which were not given constitutional deference. *Cf. Bullock v. Carter*, 405 U.S. 134 (1972) (right to run for public office is a fundamental right); *Williams v. Rhodes*, 393 U.S. 23 (1968) (right to vote is a fundamental right); *Shapiro v. Thompson*, 394 U.S. 618 (1969) (right to interstate travel is a fundamental right); *Skinner v. Oklahoma ex rel. Williamson*, 316 U.S. 535 (1942) (right to procreate is a fundamental right).

The costs of the initial utilization review are incurred by the employer or insurer. 77 Pa. Stat. Ann. § 531(6)(iii) (West Supp. 1996). Prior to Act 57, if reconsideration was sought, the costs thereof were advanced by the Bureau and the losing party was subsequently billed. 34 Pa. Code § 127.514(a). The losing party was required to reimburse the Bureau within 30 days. *Id.* However, payment of the costs imposed was not required before the losing party could file a petition for review before a Workers' Compensation Judge or subsequent appeals to the Pennsylvania

courts. Thus, the cost obligation does not preclude an employee from pursuing his/her claims through administrative procedures and the courts.

The imposition of reconsideration costs also does not amount to a judgment which the losing party may be compelled to satisfy under law. All that the challenged provisions allowed was the forwarding of a bill for the utilization review organization's charge from the Bureau to the losing party. *Id.* at §127.514(a). Before a party could be compelled to pay, the Bureau would have to obtain and execute upon a judgment pursuant to the Pennsylvania Rules of Civil Procedure. *See* Pa. R. Civ. P. 1001-1041.2, 3101-3149. The Rules of Civil Procedure provide the losing party with more than an adequate opportunity to contest its liability for the costs. *See* Pa. R. Civ. P. 1017, 1028, 1029, 1030.

In sum, Act 44 did not violate due process by imposing reconsideration costs upon the losing party.[17]

CONCLUSION

The judgment of the United States Court of Appeals for the Third Circuit should be reversed and the judgments of United States District Court Judge Buckwalter reinstated.

Respectfully submitted,

JAN M. RITCHIE
Counsel of Record
JAMES M. TYLER
PATRICIA FARRELL KERELO
JOSEPH W. CUNNINGHAM
MARK PFEIFFER
SCHUBERT, BELLWOAR, CAHILL & QUINN
Attorneys for Respondent School District of Philadelphia
1500 John F. Kennedy Blvd.
Suite 1400
Philadelphia, PA 19102
(215) 587-0146

17. The Third Circuit determined that the regulations governing the utilization review provides sufficient standards and guidance to comport with due process. Plaintiffs have not challenged that determination before this court and thus the School District need not address that issue.

Supreme Court, U.S.
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No. 97-2000

In The

Supreme Court of the United States

October Term, 1998

AMERICAN MANUFACTURERS MUTUAL INSURANCE COMPANY, *et al.*,

Petitioners,

v.

DELORES SCOTT SULLIVAN, *et al.*,

Respondents.

On Writ Of Certiorari To The United States Court Of Appeals for The Third Circuit

BRIEF OF RESPONDENTS

**LORALYN McKINLEY*
McKinley and Vonier
1333 Race Street
Philadelphia, PA 19107
(215) 569-1644

Counsel for Delores Scott Sullivan, William Battle, Anthony Cancila, Louis Baumgartner, and Class Plaintiffs

ALAN B. EPSTEIN
Jablon Epstein
A Professional Corporation
The Bellevue, Ninth Floor
Broad Street at Walnut
Philadelphia, PA 19102-3803
(215) 790-0300

Counsel for Charles Matthews, Christopher Costello, Lisa Lex, Susan Hansen, Terrance Ervine, William C. Dillon, and Class Plaintiffs

**Counsel of Record*

COCKLE LAW BRIEF PRINTING CO., (800) 225-6964
OR CALL COLLECT (402) 342-2831

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THOMAS J. O'BRIEN
Galfand, Berger, Lurie, Brigham,
Jacobs, Swan, Jurewicz & Jensen
1818 Market Street, 23rd Floor
Philadelphia, PA 19103
(215) 665-6814
Counsel for PhilaPOSH

LINDA M. MARTIN
Willig, Williams & Davidson
1845 Walnut Street, 24th Floor
Philadelphia, PA 19103
(215) 656-3600
Counsel for Intervenor
Philadelphia Federation of Teachers

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QUESTIONS PRESENTED

1. Whether insurance companies were "state actors" when, acting in conjunction with a state agency, they used statutory provisions authorizing them to stop workers' compensation medical benefits that were disabled workers' legally exclusive source of medical benefits?

2. Whether due process requires that disabled workers receive prior notice and an opportunity to be heard before their workers' compensation medical benefits can be indefinitely suspended pending utilization review and administrative hearings?

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Brest, State Action and Liberal Theory: A Case Note on *Flagg Brothers v. Brooks*, 130 Pa. L. Rev. 1296 (1982) 17

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Strickland, The State Action Doctrine and the Rehnquist Court, 18 Hastings Const. L. Q. 587 (1991) 24, 25, 32

Krotoszynski, Back to the Briar Patch: An Argument in Favor of Meta-Analysis in State Action Determinations, 94 Mich. L. Rev 25

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COUNTERSTATEMENT

This case presents a direct constitutional challenge to the utilization review procedures enacted in 1993 by the Pennsylvania legislature to amend its Workers' Compensation Act.[1] Those procedures permitted insurers or self-insured employers (hereafter "Petitioners" or "employers") to stop or supersede the workers' compensation medical benefits of thousands of injured workers, in which the workers have an undisputed property interest, without notice and with no pre-deprivation opportunity to be heard. These amendments were part of a legislative package directed at cost containment known commonly as "Act 44".

The Respondents in this case, the Plaintiffs below (hereafter "Plaintiffs" or "injured workers"), contended that the state, which administers the benefit program and has exclusive control over the resolution of disputes among the parties, violated their right to due process of law under the Fourteenth Amendment and 42 U.S.C. § 1983 when it established the procedures contained in § 306 (f.1)(5) and (6) of the Act, which delegated to the employers the power and authority to supersede an injured workers' medical benefits without any pre-deprivation notice or opportunity to be heard. *Zinermon v. Burch*, 494 U.S. 113 (1990); *Logan v. Zimmerman Brush Co.*, 455 U.S. 422 (1982); *Mathews v. Eldridge*, 424 U.S. 319 (1976).[2] Plaintiffs also sued ten named insurance carriers, contending that they were state actors in the context of the statutory scheme and therefore liable to plaintiffs for the violation of their due process rights.

The Third Circuit Court of Appeals found the Commonwealth defendants below constitutionally liable to Plaintiffs for their role in enacting and administering the challenged provisions. It further held that the employers and insurers who use the utilization review

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[1] Pa. Stat. Ann. tit.77, Sec. 1 *et seq.*, Act of June 2, 1915, P.L. 736.

[2] In bringing this challenge, Plaintiffs sued numerous state officials responsible for implementation and administration of the law as well as the ten insurers named as Petitioners in this case, who have assumed the employers' responsibilities and immunities under the terms of the Act. Plaintiffs also sued the School District of Philadelphia, representing self-insured Pennsylvania employers.

provisions to stop an injured worker's vested medical benefits pending resolution of the utilization review and appellate process, a process which can take months or years to complete, are state actors when they use those provisions.[3] In reaching this conclusion, the Third Circuit applied a flexible approach that viewed the decision to invoke utilization review in the context of the overall statutory scheme, and focused on the importance of the public benefit at issue. The court recognized the integral role that the employer plays in delivering this public benefit, and the close systemic relationship between the state and the employers in the context of utilization review, which the court found is a state created and administered mechanism that empowered the employer to supersede the public entitlement. The Third Circuit held that the Commonwealth defendants and the insurers, who are the Petitioners here, were jointly liable to Plaintiffs for the violation of their constitutional rights.[4]

Although the Commonwealth defendants filed a Conditional Cross Petition for Writ of Certiorari as to the Third

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[3] Insurers stand in the shoes of the employers, whose liability they assume, for purposes of the Act. Because there is no meaningful distinction between them, most references will be to employers, unless the Petitioners themselves are being discussed.

[4] Because of the way the Third Circuit disposed of the state action issue, it was not forced to confront the equal protection issue which would have arisen had it decided that the law violated the due process clause but that the private insurers and self-insured employers using the law were not state actors. Pet.App. at 25a. The equal protection problem would arise because it is undisputed that the State Workers' Insurance Fund ("SWIF"), which provides workers' compensation coverage not only to public employers in Pennsylvania, but to a wide array of private employers as well, is a state actor. *Rumph v. SWIF*, 964 F. Supp. 180 (E.D. Pa. 1997). *See also* Petitioner's Brief, 30 n.15. Under these circumstances an employee whose workers' compensation coverage is funded through SWIF would be afforded the protections of the due process clause, whereas an employee whose coverage is funded through a private insurer would not. There is no rational basis for such a distinction, and it could not withstand an equal protection challenge. It would also wreak havoc in Pennsylvania's workers' compensation system.

Circuits' holding against them, that petition was denied by this Court. Subsequent to the Third Circuit's decision, the Bureau changed its procedures to ensure that injured workers subject to utilization review are provided with a notice which informs them of their opportunity to submit a written statement to the utilization reviewer and that if the review is adverse, their medical benefits may be lost.[5] The Plaintiffs' case against the Commonwealth, therefore, is over and the Commonwealth defendants are not participants in these proceedings.

Because the due process issue has been resolved through the Third Circuit's holding against the Commonwealth and the Commonwealth's modification of its procedures, the only issue which requires the Court's decision is whether the Third Circuit properly held that insurers who invoke utilization review and stop the medical benefits of injured workers are state actors. To the extent that the Petitioners seek a ruling on the due process issue, they are requesting an advisory opinion which does not comport with the scope of this Court's jurisdiction under Article III of the United States Constitution.[6] *Muskrat v. United States*, 219 U.S. 346 (1911). The insurers are seeking a declaration from this Court that the right to stop the medical benefits of an injured worker, a right no longer

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[5] Joint Appendix, hereafter "Jnt. App.", at 50.

[6] The provision challenged in Plaintiffs' Amended Complaint states: "All payments to providers for treatment provided pursuant to the Act shall be made within thirty (30) days of receipt of such bills and records unless the employer or insurer disputes the reasonableness or necessity of the treatment provided pursuant to paragraph (6)" (relating to utilization review). The Third Circuit struck the "unless" clause from the statute because it allowed the employers to stop a public benefit without notice or an opportunity to be heard. Without the "unless" clause, there is no mechanism left in the statute that would allow the employers to supersede an injured worker's benefits. The Commonwealth is not defending the pre-*Sullivan* statute, and the Petitioners' due process position, therefore, raises important mootness questions. *Hall v. Beals*, 396 U.S. 45. 48 (1969).

conferred upon them by Pennsylvania law, would be constitutional should the state later decide to restore it.[7] Such a request is inappropriate and should be denied.

History and Scope of the Workers' Compensation Act

The Pennsylvania's Workers' Compensation Act (hereafter "the Act"), was passed in 1915 to compensate workers for disabilities or death suffered as a result of work-related injuries or occupational diseases. Prior to the enactment of the legislation, injured workers and their survivors could litigate claims against their employers for damages, including lost wages, medical costs, pain and suffering and other traditional tort remedies. However, because this was an action in tort, workers who failed to prove employer negligence were left with no remedy at all. *See Krawchuk v. Philadelphia Electric Co.*, 497 Pa. 115 (1981).

The Act reflected a major compromise in the interests of both employers and employees. In exchange for the guarantee

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[7] Petitioners' due process challenge is incomprehensible as it confuses their request for a prospective advisory ruling with the remedy which should flow from their past use of the unconstitutional procedures. The Third Circuit's ruling as to the state's notice procedures and its requirement that Plaintiffs be given an opportunity to be heard were premised upon the duty of the Commonwealth to provide procedural protections *before* the deprivation of benefits took place. The Petitioners have not challenged the Third Circuit's holding that the lack of notice and opportunity to be heard in the state's procedures rendered the statute unconstitutional. *See Petitioner's Brief at 30.* Having conceded that the lower court's constitutional ruling as to notice and opportunity to be heard were correct, their contention here that the pre-deprivation supersedeas would be constitutional, if it still existed, makes no sense. If the statute was unconstitutional as presented to the Third Circuit, the only issue properly before the Court is whether the Petitioners were state actors when they invoked it. The inquiry as to whether the supersedeas of benefits by them pursuant to the procedures as modified by the state would make them liable for the constitutional violation prospectively has nothing to do with whether they are liable to Plaintiffs for the deprivation which took place under the original statutory provisions, which concededly provided neither notice nor an opportunity to be heard.

of payment for wage loss and medical costs from injury regardless of fault, the employee forfeited her constitutional right to sue her employer in tort. *Winterberg v. Transportation Insurance Co.*, 72 F.3d 318 (3d Cir. 1995). Workers' compensation became the exclusive remedy for work related injuries in Pennsylvania. 77 P.S. § 481; *Bayless v. Philadelphia National League Club*, 472 F. Supp. 625 (E.D. Pa. 1979), *aff'd*, 615 F.2d 1352 (3d Cir. 1980).[8]

In 1974, the Act was amended, making it *mandatory* for employers to provide workers' compensation coverage for their employees. Act of Dec. 5, 1974, P.L. 782, 784, Pa. Stat. Ann. tit. 77, § 461, 481(a). Under the Act, employers may satisfy their obligation to insure against their employees' work-related injuries or occupational diseases in one of three ways: (1) the employer may retain a "private" insurance carrier authorized by the Pennsylvania Insurance Department to sell or issue workers' compensation insurance in Pennsylvania; (2) the employer may insure itself through SWIF, a fund created by the General Assembly and administered by state employees and officers; or (3) the employer may self-insure. Any employer who fails to obtain coverage through one of these methods is subject to fines, imprisonment, or both. *Id.* at § 501. In the event that an employer cannot procure insurance coverage, the state, through SWIF, will provide the insurance itself. *Id.* In the event of insolvency the state provides benefits to injured workers through a state administered security fund. 77 Pa. Stat. Ann. § 1055.

Thus, the workers' compensation system is not a private insurance model. *Winterberg*, 72 F.3d 318, 325, n.4 (3rd Cir. 1995) (distinguishing workers' compensation from private insurance). Although private insurers and employers participate in the provision of benefits, the workers' compensation system in Pennsylvania is a comprehensive public benefit

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[8] Pursuant to the statute, the insurer not only assumes all of the employer's liability, but also, is "entitled to all of the employer's immunities and protection" under the Act. 77 P.S. 501(a)(1). Accordingly, an injured worker cannot sue the insurer for bad faith, a right he would have outside the context of the Act.

mechanism intended to fulfill important constitutional and statutory objectives.[9] Unlike under private insurance, the injured worker has a statutory right to have the wage and

[9] The Petitioners vigorously dispute that workers' compensation benefits in Pennsylvania are public benefits. They cite no legal authority for their contention, and rely upon patently inapt analogies to deny what has been explicitly stated by the Pennsylvania Supreme Court, *i.e.*, that workers' compensation benefits are not a matter of contract, but are provided as a statutory entitlement through the Commonwealth's police power. *Bible v. Department of Labor and Industry*, 548 Pa. 247 (1997); *Hankee v. Wilkes-Barre/Scranton Int'l Airport*, 532 Pa. 494 (1992). That workers' compensation benefits are public benefits as a matter of law is evident from the following: the right to workers' compensation is guaranteed to all workers in Pennsylvania who are not self-employed, and this guarantee is enforced by the state. Workers cannot bargain away their right to workers' compensation, and they may not opt out in favor of their own privately obtained coverage. A plaintiff aggrieved by the conduct of his employer or its insurer cannot drop his coverage and shop for a new carrier and he may not procure care for his injuries outside the provisions of the Act. 77 P.S. § 531(3)(i). He is not a party to any contract other than the one with his employer; moreover, the employer's duty to provide for workers' compensation does not emanate from a contract or insurance policy, but from state law; workers' compensation constitutes a *quid pro quo* for the right of workers to sue their employers for damages as a result of workplace injuries. It is the exclusive remedy for such injuries. *Winterberg, supra*. The private resolution of workplace injuries through civil litigation was replaced by a publicly administered Bureau which dictates the level of benefits to be paid, the circumstances under which benefits can be paid, as well as those under which they can be suspended and terminated. The Bureau is an integral participant in the statutory model. Workers' compensation has been deemed by the Pennsylvania Courts to be a public benefit, equivalent to "a soldier's right to a pension". *Keller v. Old Lycoming Township*, 286 Pa. Super. 339, 348 n.6 (1981). *See also* ten Broek, *Disability and the Law of Welfare*, 54 Cal.L.Rev. 809, 822 (1966) ("governmental discretion as to the amount, character, and conditions of aid, and governmental machinery and technical apparatus brought to bear upon the assessment of individual need, are prime characteristics of the system of public welfare").

medical coverage provided to him or her at no charge. This coverage is guaranteed by the Commonwealth, which vigorously enforces the entitlement through the Bureau of Workers' Compensation ("the Bureau").

Conversely, the injured worker has no right to opt out of the workers' compensation system, in favor of his own private insurance coverage or no coverage at all. 77 P.S. § 481(a). Moreover, the injured worker is statutorily prohibited from securing medical services for work-related injuries from his own funds. 77 P.S. § 531(3)(i). In addition, the employee has no right to choose the provider of his benefits. The employee is a captive of whatever carrier the employer contracts with, subject to the protections of the Act.

The Operation of The Workers' Compensation System

The Bureau works hand in hand with employers to provide benefits to injured workers. Whether benefits are paid by the employer directly, through SWIF, or by a commercial insurer, the Bureau is an integral participant in the operation of the statute. It actively enforces the Act's mandates and is authorized to ensure compliance by insurers through the assessment of monetary penalties for violation of its provisions. 77 P.S. § 701. Pursuant to its statutory authority, the Bureau has adopted regulations implementing the Act and has imposed numerous reporting requirements upon employers and insurers involved in the system. 34 Pa. Code § 121.1 *et seq*. For uniformity and ease of administration, the Bureau has developed numerous forms for each of these reporting requirements. Use of these forms is mandatory. 77 P.S. §§ 717.1, 711, 731.

The Bureau is more than a passive repository for completed forms, however. The mandated documents reflect the legal status of every injured employee. The Bureau not only collects these documents, but reviews them for compliance with the Act. 77 P.S §§ 715, 731. In the event of a dispute between the parties, these documents will provide the basis on which the state ultimately determines the injured worker's entitlement. 77 P.S. § 731. They also provide a foundation for enforcement actions against employers or insurance carriers

which the Bureau determines are in violation of the provisions of the Act. 77 P.S. § 991.

Baksalary v. Smith Holds Automatic Supersedeas Unconstitutional

From 1984, until the Pennsylvania Legislature passed Act 44, which encompasses the utilization review provisions at issue in this case, an employee eligible to receive workers' compensation benefits[10] could not have those benefits stopped without his consent, even temporarily, without an order from a workers' compensation judge. This was the result of a federal court order in *Baksalary v. Smith*, 579 F. Supp. 218 (E.D. Pa. 1984), *appeal denied*, 469 U.S. 1146 (1985) *aff'd*, 772 F.2d 893 (3d Cir. 1985). A unanimous three-judge panel[11] in *Baksalary* invalidated a portion of Section 413(a) of the Act, which had provided for the automatic cessation, or supersedeas, of workers' compensation benefits upon an employer's filing of an affidavit of recovery with the state workers' compensation authorities, accompanied by a physician's affidavit, or an affidavit that the worker had returned to work. A supersedeas invoked in this way would remain in effect throughout the litigation over whether the employee's

[10] Petitioners imply that the insured workers have obtained their current medical treatment with no screening process and that, therefore, the reasonableness and necessity of the treatment has never been ascertained, to the unfair detriment of the insurers. This is not the case. A person can become entitled to workers' compensation benefits either by voluntary agreement between the parties or the unilateral acknowledgment by the employer that the injury is compensable. Alternatively, eligibility can be established through a favorable decision by a workers' compensation judge after extensive hearings. 77 P.S. § 717(1), 731, 751. Each of the named plaintiffs and each member of the class they seek to represent have become entitled to receive workers' compensation medical benefits through one of these mechanisms. They are not applicants, but pursuant to the terms of the Act, have been determined eligible for the medical benefits they were receiving at the time those benefits were stopped.

[11] *Baksalary* was decided by a three judge court convened under 28 U.S.C. § 2281, *repealed* Pub. L. 94-381, §§ 1, 2 *effective* Aug. 12, 1976, 90 Stat. 1119.

right to benefits should be permanently terminated or suspended.

The *Baksalary* court held that the automatic supersedeas provision contained in Section 413(a) was unconstitutional because it deprived injured workers of a property right in their workers' compensation benefits without notice or an opportunity to be heard. In reaching that decision, the court held that insurers and self-insured employers were state actors for purposes of the Fourteenth Amendment when they invoked the automatic supersedeas provision of Section 413(a). This was based upon the formal and systematic participation of state personnel which was triggered by the employer's invocation of supersedeas in each case.

The *Baksalary* decision was followed by a consent decree that eliminated the automatic supersedeas provision of Section 413(a). *Baksalary v. Smith*, 591 F. Supp. 1218 (E.D. Pa. 1984). Unless an injured worker returned to work with no wage loss, there was no remaining provision in the Act by which an automatic and unilateral cessation of workers' compensation benefits could be achieved. All terminations of benefits, even temporary ones, were required to be preceded by fair notice and a hearing.[12]

Medical Disputes Prior to Act 44

After *Baksalary* and before the passage of Act 44, all disputes about medical treatment were completely protected from unilateral cessation by an employer or insurer. Disputes as to the reasonableness and necessity of the treatment, (the focus of utilization review), were exclusively resolved by petition filed with the Bureau and assigned to a workers' compensation judge. There was no provision for supersedeas

[12] The automatic supersedeas invalidated in *Baksalary* operated upon both wage loss and medical benefits. Where medical benefits were the only issue being contested, § 413(a) did not apply. Such reviews were conducted pursuant to Section 306(f), which specifically prohibited the supersedeas of those benefits while under review, automatically or otherwise. 77 P.S. § 53.

of medical treatment pending review.[13] Injured workers were given the opportunity to appear at hearings and testify on their own behalf. They had the right to be represented by counsel. They had the opportunity to present medical evidence and cross examine the employer's medical expert. With the closing of the record, the Judge would issue a decision containing findings of fact and conclusions of law based on the evidence. If the Judge ultimately decided that the treatment was reasonable, the injured worker would continue to receive it without an interruption in service. If not, the insurer would be relieved of the obligation of further payment, and would be reimbursed by a state supersedeas fund for payments which had been made for treatment deemed unreasonable. *ADIA Personnel Agency v. Workers Compensation Appeal Board, supra.*

The Passage of Act 44

In June 1993, in response to political pressure from employers and insurance carriers about the rising cost of medical treatment, the Pennsylvania General Assembly passed a measure known as Act 44, which set forth provisions for medical cost containment, including the utilization review provisions at issue here. Section 306(f.1)(5), like the provision invalidated in *Baksalary*, operates upon injured workers whose eligibility to receive workers' compensation benefits, including medical treatment, has already been established. 77 P.S. § 531(5). It provides a mechanism for employers to stop the medical component of those benefits without any showing of medical justification, with no prior notice to the injured

[13] The pre-Act 44 Section 306(f)(2)(II), 77 P.S. § 531, stated, "The employer shall have the right to petition the department for review of the necessity or frequency of treatment . . . Such a petition shall in no event act as a supersedeas, and during the pendency of any such petition, the employer shall pay all medical bills if the physician or other practitioner of the healing arts files a report or reports as required [by the Act]." *See also ADIA Personnel Agency v. Workers Compensation Appeal Board*, 137 Pa.Cmwlth. 405 (1991) (workers' compensation referee had no authority to order discretionary supersedeas of challenged medical benefits pursuant to Section 306(f)).

worker or any opportunity to respond, upon the filing of a request for utilization review with the Bureau and subject to the Bureau's acceptance of the request. The Bureau refers requests for utilization review to Utilization Review Organizations ("URO's"), which are approved, trained and supervised by the Bureau. The URO's review the challenged treatment, and determine whether the medical benefits at issue must be paid.

The Bureau serves the dual function of gatekeeper and traffic cop for the utilization review process. Access to the utilization review system can only be invoked by filing a form devised by the Bureau for that purpose. Employers are empowered by the statute, upon approval by the state, which reviews the form to determine if the request is proper and submitted in timely fashion, to stop payments for challenged medical treatment. In order to maintain the supersedeas, the request for utilization review must be accepted by the Bureau. If it is, the supersedeas may extend throughout the review process, which can take months, or even years, to complete. If the request is not approved, the supersedeas is rescinded. There are numerous reasons that a request for utilization review can be rejected by the Bureau.[14] The Bureau rejects requests for review twenty per cent of the time. Third Cir. App. at C-50.

Absent a sufficient and proper request to the Bureau for utilization review, the medical benefits at issue must be paid

[14] These include: failure of an insurer or employer to accept liability for the work-related injury; failure to certify proof of service, to sign the request, to identify the type of treatment or procedure to be reviewed, or to provide information needed by the Bureau to process the request; the form is also rejected if there is pendency of the same issue before the peer review authorities by request of a workers' compensation judge; because the request seeks review of treatment that occurred before August 31, 1993, or seeks review of the relatedness of treatment to a work injury; because it was not preceded by an initial utilization review, where applicable; inconsistency between the provider and the treatment to be reviewed and/or lack of specificity concerning treatment dates.

within thirty days of their submission to the insurance company. 77 P.S § 531(5). Otherwise, this obligation can only be extinguished by an order of a workers' compensation judge or the consent of the injured worker. If an employer or insurer takes a supersedeas which has not been authorized by proper invocation of utilization review, it is subject to penalties pursuant to Section 435 of the Act, 77 P.S. § 991. The Bureau's Compliance Division is also authorized to take action against the non-paying employer. Finally, the employer's obligation to pay can be enforced by a medical provider through a Petition for Fee Review, which can result in an order to pay and the imposition of an interest award against the insurer or employer.

Upon approval of a request for utilization review, the Bureau assigns the case to a URO and provides notice of the assignment to the injured worker, the insurer, the employer and the medical provider under review, with instructions to the URO and the medical provider. Prior to the Third Circuit's decision in this case, there was no notice to injured workers that their medical benefits might be stopped. In the usual case, the workers would learn from the medical providers that benefits had been stopped, and, in most cases, that treatment would no longer be provided.

Once the URO receives the assignment, it is required to render a decision within sixty days of the assignment as to whether the challenged treatment is reasonable and necessary. 77 P.S. § 531(6)(ii).[15] Prior to the Third Circuit's decision, the injured worker was precluded from any participation in the utilization review, either directly or through counsel. The URO was instructed by the Bureau not to discuss the treatment under review with the injured worker or his or her attorney, and could not accept documents or other evidence from the injured worker. The URO is statutorily directed to

[15] The statute does not dictate how long the Commonwealth has to make the assignment. Thus, the initial review may be delayed well beyond the sixty days provided in the statute, as some of the named plaintiffs have alleged, *See* Jnt. App. at 39, ¶ 231 (assignment took 32 days); ¶250-1(42 days).

file a copy of its report with the Bureau, which monitors and supervises the performance of the URO's.[16]

District Court Proceedings

On January 12, 1995, Plaintiffs filed their initial complaint challenging the supersedeas provisions contained in Section 306(f.1)(5).[17] They claimed that those provisions

[16] Petitioners deny that medical benefits are at issue at all, characterizing the dispute as one over "bills", rather than treatment, and by insisting that the Plaintiffs can be fully reimbursed later for any loss they incur now. This mischaracterizes the nature of the benefit delivery system at issue here, which provides benefits to injured workers through the receipt of treatment, and not by way of direct payments to injured workers. In practice, those benefits are furnished through the payment of medical bills submitted by medical providers to the insurance company or employer. Thus, while it may be true in some sense that "bills" are at issue here, those bills are merely the vehicle through which medical benefits are provided under the Act. When the bills are not paid, Plaintiffs' treatment is ordinarily stopped, and benefits are thereby eliminated. The consequences of this can be severe and permanent. This is particularly true where the length of the deprivation is prolonged, as the Plaintiffs have alleged here. Moreover, it is simply not true that the dispute centers around treatment which has already been delivered. In some cases, where a discrete procedure is involved, this may be the case, but in most cases, like those of the named Plaintiffs, the utilization review was used to supersede not only payment for past treatment, but for ongoing treatment as well. As the named Plaintiffs have alleged, such treatment will not be restored until after the utilization review has been completed, including, if the initial review is adverse to the injured worker, appeals to the workers' compensation system.

[17] Petitioners object to the term "supersedeas" because that term does not appear in the statute. Plaintiffs have used the term throughout this litigation because the challenged provisions permit employers to supersede, or stop, their medical treatment. Even the Director of the Bureau has referred to it as an "automatic supersedeas". *See* Appendix to Plaintiff's Motion for Partial Summary Judgment, Exhibit "F" at 11. Plaintiffs continue to use the term supersedeas because it is most descriptive of what the statute provides. To supersede is to "set aside, render unnecessary, suspend or stay". BLACK'S LAW DICTIONARY, 4th Ed. (1951).

violated their right to due process of law, because they provided for the cessation of workers' compensation medical benefits pending "utilization review" with no pre-deprivation notice or opportunity to be heard.

The originally named Plaintiffs included seven seriously injured workers whose benefits had been stopped under the supersedeas procedure of 306(f.1)(5), and the Philadelphia Area Project on Occupational Safety and Health (Phila-POSH). They initiated, on behalf of themselves and a class of similarly situated injured workers, a facial challenge to the constitutionality of Sections 306(f.1)(5) and (6) of the Act.

The named defendants included the Commonwealth through four state officials responsible for designing, implementing, administering and enforcing the Act, the director of the legislatively created State Workers' Insurance Fund (SWIF), the School District of Philadelphia, which is a self-insured public employer, and seven of the ten insurance carriers who are Petitioners herein, licensed to write workers' compensation insurance policies in Pennsylvania. On March 30, 1995, the Philadelphia Federation of Teachers was permitted to intervene as an additional plaintiff.

On April 10, 1995 the insurers moved under Federal Rule of Civil Procedure 12(b)(6) to dismiss the complaint as to them, alleging that they were not state actors for purposes of the Fourteenth Amendment. On January 24, 1996, the district court entered an order granting the defendant insurance companies' motion to dismiss.

On May 29, 1996, Respondents filed an Amended Complaint which added three additional plaintiffs (also Respondents herein) and additional constitutional claims.[18] The

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[18] The Amended Complaint extended Plaintiffs' challenge to include the utilization review provisions which are contained in Section 306(f.1)(6). Plaintiffs also made a due process attack upon the fees imposed in the reconsideration review process, and the lack of standards to govern utilization review and appeals therefrom. The Third Circuit ruled against the Plaintiffs on the latter claim, but remanded for further proceedings on the reconsideration issue. This claim was a systemic one

insurers were served with the Amended Complaint, and at the same time dismissed from the case in light of the court's prior state action decision. On June 19, 1996, the Commonwealth defendants filed a motion to dismiss the Amended Complaint. By order dated November 8, 1996, the court dismissed the Commonwealth defendants, finding that Sections 306(f.1)(5) and (6) caused a deprivation of a property interest, but that the provisions were nonetheless constitutional. This left the School District as the sole remaining defendant. The School District filed a Motion for Judgment on the Pleadings based upon the court's finding of constitutionality. This motion was granted on December 16, 1996. This constituted a final order, from which Respondents appealed to the United States Court of Appeals for the Third Circuit.

The Appellate Proceedings

On March 13, 1998, the United States Court of Appeals for the Third Circuit reversed the decisions of the district court and held that the supersedeas provisions of the Act violated the requisites of procedural due process. Citing to the well-worn precedents of this Court, the Third Circuit held that both the lack of adequate pre-deprivation notice and the denial of an injured worker's right to be heard rendered the supersedeas provisions constitutionally infirm.[19]

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which ran against the Commonwealth defendants. It was settled on August 19, 1998 at a meeting of all counsel to the proceedings below. Plaintiffs cannot fathom, therefore, why it is addressed in the School District's brief. It was not raised in any of the Petitions for Certiorari, including the School District's, which was denied by the Court, and is clearly not before the Court for disposition.

[19] "[W]e hold that the supersedeas provisions under § 531(5) and (6) violate the dictates of due process by not affording disabled employees notice or an opportunity to be heard before their medical benefits are suspended. To remedy the procedural defects in the statute, at minimum, an employee must be given: (1) timely and reasonable notice of the imminent suspension of the medical benefits and treatment before the suspension takes effect; (2) a description of the reasons why utilization review has been invoked; (3) an opportunity and time to submit a personal statement in writing regarding the employee's view of the reasonableness and/or

More important to the issues presented here, the Third Circuit held that the insurers were state actors when they invoked the unconstitutional supersedeas provisions in the Act. Relying on *Edmonson v. Leesville Concrete Co.*, 500 U.S. 614 (1991)and *Tulsa v. Professional Collection Services, Inc. v. Pope*, 485 U.S. 478 (1988), the court found that the decision to invoke utilization review was not self-executing, but rather, required the overt assistance of the Bureau. The court held that," [t]he [Bureau] is intimately involved throughout, and without that involvement the supersedeas could not operate." Pet. App. at 15a.

I. INTRODUCTION AND SUMMARY OF ARGUMENT

The Plaintiffs in this case have directly challenged the constitutionality of § 306(f.1)(5) and (6) of the Pennsylvania Workers' Compensation Act, which delegates to employers the power to stop the medical benefits of injured Pennsylvania workers. Because Plaintiffs are making a facial challenge to the constitutionality of the utilization review procedures in the Pennsylvania Act, (a challenge directed equally against the Commonwealth Defendants and the Petitioners), this case falls squarely within a well established line of Supreme Court precedents that have found state action on the part of a private actor or entity without applying the discrete state action "tests" relied upon by Petitioners. *Tulsa, supra*; *Reitman v. Mulkey*, 387 U.S. 369 (1967); *Smith v. Allwright*, 321 U.S. 649 (1944); *Nixon v. Condon*, 286 U.S. 73 (1932); *Accord New York Times Co. v. Sullivan*, 376 U.S. 254 (1964). In these cases, the challenge to the constitutionality of the state law by necessity places the focus on the state statute and its underlying policy, regardless of the identity of the defendant, and requires the court to analyze within the context of the overall statutory scheme, any act or decision by a private actor or entity who is relying on the challenged law. *See, e.g., Tulsa,*

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necessity of the disputed medical treatments; and (4) a description of the procedures under which the employee can appeal an adverse determination." Pet. App. at 33a.

485 U.S. at 480. In applying this contextual approach to the state action issue, this Court has relied upon the totality of the circumstances, and framed the issue in terms of whether, after passage of a given act, the state's involvement with the statute (as opposed to that of the private actor or entity) is substantial enough to implicate the protections of the Constitution. *Tulsa*, 485 U.S. at 486.

When a facial challenge is made to the constitutionality of a state law, the first question the Court must address is not whether the private actor or entity invoking the law is a state actor, but rather, whether the challenged provisions of the law are constitutional. *See, e.g., Tulsa, supra*. Significantly, when the Court has used this approach, and found that the law violates the procedural due process or the equal protection clause, it has invariably found that the private actor or entity invoking or relying on the unconstitutional law is a state actor. *Tulsa, supra*; *Fuentes v. Shevin*, 407 U.S. 67 (1972); *Sniadach v. Family Finance Corp.*, 395 U.S. 337 (1969); *Reitman v. Mulkey, supra; Smith v. Allwright, supra*; *Nixon v. Condon, supra*; *Accord New York Times, Co. v. Sullivan, supra*.[20]

Pursuant to the above cited line of cases, the Petitioners' reliance on the unconstitutional provisions of the Pennsylvania statute to stop Plaintiffs' entitlement to medical treatment was clearly state action. In invoking the unconstitutional provisions of the Pennsylvania Act, which delegated to employers the power to terminate a vested state entitlement, Petitioners were not only exercising a state granted power, but also, promoting the state's policy of cost containment. The purpose and effect of the 1993 Amendments to the Pennsylvania Workers Compensation Act was therefore to enlist or "harness the energies of private groups to do indirectly what

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[20] In cases such as *Fuentes* and *Sniadach* the Court did not even feel the need to address the state action question, as the facial attack apparently rendered that unnecessary. *See generally* Brest, "State Action and Liberal Theory: A Casenote on *Flagg Brothers v. Brooks*", 130 Pa. L.Rev. 1296 (1982).

[the state] could not [constitutionally] . . . do [itself]". *Reitman*, 387 U.S. at 383 (Douglas, J., concurring); *Cf. Lebron v. National Railroad Passenger Corp.*, 513 U.S. 374, 397 (1995) ("It surely cannot be that government, state or federal, is able to evade the most solemn obligations imposed in the Constitution by simply resorting to the corporate form."). In promoting the state's policy, Petitioners represented the state and became its agent. *Nixon*, 286 U.S. at 89. As the above cited line of cases teaches, "the government's reliance on the willing compliance of private citizens is a factor increasing – not diminishing – the government's involvement," thereby rendering the private citizen, whose energies were harnessed by the express authorization of the statute, a state actor. *Alliance For Community Media v. F.C.C.*, 10 F.3d 812, 822 n.13 (D.C. Cir. 1993), *aff'd in part, reversed in part*, 516 U.S. 973 (1995).

In stark contrast to the cases involving a direct challenge to the constitutionality of a state statute are those primarily relied upon by Petitioners, which, because they did not involve a direct constitutional challenge, steer the court's focus away from the state and on to the conduct or decision of the private actor or entity.[21] Because in these cases the law or regulation relied on by the private actor or entity was not directly challenged as unconstitutional, the state was not directly implicated in the private act or decision. Thus, in order to determine whether the private conduct or act could be deemed "fairly attributable to the state", the court had to rely on certain guiding principles. *Edmonson, supra*, 500 U.S. at 621-23. While it is Plaintiffs' position that their facial challenge to the constitutionality of the Pennsylvania Act renders these guiding principles and the decisions that established and utilized them inapplicable to this case, even assuming that they do apply, Plaintiffs contend that the Petitioners both misstated and misapplied the appropriate principles, and that

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[21] *See eg. Rendell-Baker v. Kohn*, 457 U.S. 830 (1982); *Blum v. Yaretsky*, 457 U.S. 991 (1982); *Flagg Brothers , Inc. v. Brooks*, 436 U.S. 149 (1978); *Jackson v. Metropolitan Edison Co.*, 419 U.S. 345 (1974).

the Third Circuit's approach was consistent with this Court's most recent state action cases. Indeed, Petitioners' rigid approach completely ignores the evolution of the doctrine set forth in this Court's most recent state action pronouncements. *Id.; West v. Atkins*, 487 U.S. 42 (1988). Contrary to this Court's flexible, contextual approach to discerning state action, Petitioners argue for the strict application of discrete tests (public function, symbiotic relationship, state compulsion), and would require satisfaction of those tests individually before state action could be found.

On numerous occasions this Court has stated that the so-called "tests" espoused by Petitioners are in reality only factors or guiding principles to be considered in the overall analysis as to whether, given all the facts and circumstances of the particular context, state action can be said to exist. Plaintiffs contend that this totality approach is the appropriate one for the Court to continue to employ and that, under it, the insurers are clearly state actors when invoking the utilization review process. In addition, Plaintiffs also contend that even under the more restrictive approach that Petitioners have asked this Court to adopt, the insurers' role in the utilization review process renders them state actors.

II. THE THIRD CIRCUIT CORRECTLY HELD THAT THE UTILIZATION REVIEW PROVISIONS VIOLATED DUE PROCESS

While it is the Plaintiffs' contention that the due process issue is not appropriately before this Court, the Third Circuit's due process decision was based on this Court's well established precedent and is virtually unassailable. The court held that the utilization review provisions violated due process because the statute provided no notice to Plaintiffs prior to the supersedeas of their medical benefits, and offered the injured workers no opportunity to challenge the suspension of their medical benefits until many months (at least) after the deprivation of those benefits had been effected. The court found the lack of pre-deprivation notice to the injured worker

to be constitutionally fatal.[22] Moreover, the court observed, the notice arrived after the benefits had already been stopped. The court noted the Commonwealth's concession that no notice is afforded to the injured worker under the statute, and concluded that inadequate notice effectively strips an injured worker of his ability or opportunity to protest or minimize unjustified deprivations. The court held that due process requires some sort of opportunity to be heard regarding the basis of the proposed termination before it takes place.

The Third Circuit's holding is a mainstream decision consistent with a well-settled and unbroken line of precedent from this Court, which sets forth two basic tenets of due process. First, "notice reasonably calculated under all the circumstances to apprise interested parties of the pendency of the action" is constitutionally required prior to the deprivation of a protected property interest. *Memphis Light, Gas & Water Div. v. Craft*, 436 U.S. 1, 13 (1978); Second, due process ordinarily requires an opportunity for "some kind of hearing" prior to the deprivation of such an interest. *Memphis Light, Gas & Water, supra*, 436 U.S at 19, *citing, Boddie v. Connecticut*, 401 U.S. 371, 379 (1971). *See also Logan v. Zimmerman Brush Co.*, 455 U.S. 422, 437 (1982). In a case such as this, in which an established state procedure is being challenged, this Court has always required notice and an opportunity to be heard *before* the deprivation, unless exigent circumstances exist or pre-deprivation process would be demonstrably impracticable. *Zinermon v. Burch*, 494 U.S. 113 (1990); *Parratt v. Taylor*, 451 U.S. 527 (1981). This is true even if extensive post-deprivation remedies are afforded. *Connecticut v. Doehr*, 501 U.S. 1 (1991).

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[22] The Third Circuit found the notice constitutionally defective in many respects: "[It] does not explain that a supersedeas or suspension of one's medical benefits may result nor does it explain what utilization review entails. In addition, it does not inform an employee of any procedures under which the employee can protest the suspension of the medical benefits or contest the merits on which the proposed deprivation is based." Pet. App.at 23a.

This Court has applied these principles in numerous factual contexts to invalidate state laws that failed to provide any notice or opportunity to be heard before the deprivation of a protected liberty or property interest.[23] These cases and the due process principles enunciated in them apply to interim deprivations of property as well as to final deprivations. *See, e.g., Connecticut v. Doehr*, 501 U.S. at 12; *Arizona v. California*, 460 U.S. 605, 638 n.28 (1983).

Because no one disputes that the challenged statute permitted a recognized property right to be disrupted without any pre-deprivation notice, the Third Circuit's decision that the statute was unconstitutional must stand regardless of how this Court might view the other due process concerns raised by Petitioners. Inadequate notice is enough by itself to render the statute unconstitutional and is enough to support the Third Circuit's due process holding. *See, e.g., Memphis Light, supra; Mullane v. Central Hanover Bank and Trust Co.*, 339 U.S. 306, 314 (1950).

The Third Circuit's determination that the lack of a prior opportunity to be heard renders the statute unconstitutional also must be upheld. Once it is established that pre-deprivation process is due, *Mathews, supra*, defines the extensiveness of the procedures to be afforded. The Third Circuit straightforwardly applied the three *Mathews* factors and concluded that the injured workers must be afforded an opportunity to submit a personal statement in writing to the utilization reviewer before his benefits can be stopped. The Court looked first at the private interests involved, including the injured workers' interest in the relief that medical treatment provides, and the interest of the insurers and employers in not paying for unnecessary and unreasonable medical treatment. While

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[23] *Connecticut v. Doehr, supra* (real estate attachment); *Cleveland Board of Education v. Loudermill*, 470 U.S. 532 (1985) (public employment); *Logan v. Zimmerman Brush, supra* (cause of action); *Memphis Light, Gas & Water Division, supra* (utilities); *Goss v. Lopez*, 419 U.S. 565 (1975) (public education); *Fuentes v. Shevin*, 407 U.S. 67 (1972) (personal property); *Bell v. Burson*, 402 U.S. 535 (1971) (drivers licenses); *Goldberg v. Kelly*, 397 U.S. 254 (1970) (welfare benefits)

the employers' interest was pecuniary, the injured workers' was not. Their interest was considered by the Court to be significant.[24] The Court further concluded that the risk of erroneous deprivation was unacceptably high, given the injured workers' lack of notice and opportunity to be heard during the utilization review process. Although the review focuses upon the medical records of the treating physician, and the physician must be given the chance to speak with the reviewer, the court was "hard-pressed to believe that the portrait of the employee's illness and treatment . . . [could be] . . . complete without a statement or other input from the injured worker". Pet. App. at 29a. The governmental interest, according to the court, would also be served by permitting the injured worker a pre-termination opportunity to respond. The government has a legitimate interest in containing costs and ensuring that benefits are paid only for reasonable and necessary treatment, but has an equally compelling interest in preventing the erroneous termination of benefits to injured workers who have a continuing need for them. On balance, therefore, some sort of pre-deprivation process would be

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[24] The Petitioner-Insurer's assertion that the Third Circuit failed to take their interest into account was erroneous. The court factored their interest into the *Mathews* analysis but concluded that it was not as significant as the injured workers' in light of the purposes and policies of the Act. While the insurers' interest could be quantified in monetary terms, timely medical treatment only has value at the time it is needed, and the consequences of delay in this context can lead to medical consequences which can never be rectified through the retroactive payment of money. Pet. App. at 28a; *See also Memorial Hospital v. Maricopa County*, 415 U.S. 250, 259-261 (1974). It should be noted that the Pennsylvania courts have balanced the interests of employers and injured workers and come to the same conclusion as the Third Circuit did. *Stonebraker v. Workers' Compensation Appeal Board*, 163 Pa.Cmwlth. 468, 475 (1994) (despite employer's economic interest in terminating medical treatment which is not necessary as soon as possible, injured workers should be protected from potentially devastating economic or medical consequences stemming from unwarranted terminations of medical benefits).

necessary. Pet. App. at 30a. At a minimum, the Court concluded, "the employee should be granted the opportunity to present additional evidence such as his/her personal testimony in writing as to the reasonableness and necessity of the disputed treatment". Pet. App. at 31a.

The Third Circuit's holding was well within the parameters set forth in *Mathews*. Indeed, the plaintiff in *Mathews* received far more in the way of pre-deprivation process than did the *Sullivan* plaintiffs. Moreover, the Petitioners have alleged no exigency which would justify a departure from the fundamental requirements of pre-deprivation process. Neither is impracticability a barrier, as demonstrated by the existence of a system for the predeprivation review of medical benefits prior to the adoption of the utilization review provisions at issue here, and the implementation of prior notice and opportunity to be heard by the Commonwealth defendants following the Third Circuit's decision. Even in those rare situations in which this Court has approved post-deprivation procedures alone, it has required some assurance against arbitrary and unfounded interference in the enjoyment of the property interest. *E.g., Connecticut v. Doehr, supra*. Here, there is no such assurance. The employer's request for utilization review is not required to be based on any medical criteria whatsoever, or supported by even the slightest indicia of reasonableness. This Court has found on numerous occasions that "one-sided, self-serving, and conclusory submissions" elevate the risk of erroneous deprivation to an unacceptable level. *Id., Fuentes v. Shevin, supra*, 407 U.S. at 83.

Underlying the Petitioners' argument is the fundamental complaint that due process was found to attach at all, because what is at issue here, in their view, is not the deprivation of medical benefits, but the timing of payment for treatment already received. Bills, not benefits, is how the Petitioners would like to characterize what is at stake here. Petitioners' argument grossly mischaracterizes the record and the clear import of a request for utilization review. Medical bills are the vehicle through which medical benefits are delivered to injured workers in Pennsylvania. These benefits are public

benefits and the state has exclusive control over the resolution of disputes among the parties in the administration of those benefits. The procedures so utilized must satisfy due process. *Logan v. Zimmerman Brush*, 455 U.S. at 429 n.5. Unless the doctor or other medical provider agrees to work for free, once payments stop, so does the treatment. Several of the Plaintiffs in this action have alleged that their ongoing medical treatment was stopped once the insurer or employer stopped paying for it on the basis of a utilization review request. They are precluded by law from paying for those services themselves in the interim, and thus, unlike the Plaintiff in *Mathews*, have no access to substitute services while they await the outcome of utilization review.[25]

III. PLAINTIFFS' FACIAL CHALLENGE RENDERS THE DISCRETE TESTS INAPPLICABLE AND DIRECTLY IMPLICATES THE STATE IN THE DECISION TO STOP MEDICAL BENEFITS.

It is a basic proposition that a State acts through its legislative, its executive and its judicial branches. *Ex Parte Virginia*, 100 U.S. 339, 347 (1879). The enactment of a state law and its enforcement is undisputably state action. *Tulsa*, 485 U.S. at 486-87; *New York Times*, 376 U.S. at 265; *Paul v. Watchtower Bible and Tract Society*, 819 F.2d 875, 880 (9th Cir. 1987); Strickland, *The State Action Doctrine and the Rehnquist Court*, 18 Hastings Const. L. Q. 587, 598, 601-602 (1991). When a facial challenge is made to the constitutionality of a state law and its enforcement in a particular

[25] None of the Petitioners ever challenged the accuracy of this fact in the proceedings below, nor could they, given the explicitness of the law on this point. The fact that one of the named Plaintiffs was forced by a medical provider to pay for her treatment during utilization review does not change the fact that it was illegal for the doctor to demand payment from her. David Weyl, Chief of the Bureau's Cost Containment Division testified emphatically on this point: "If that provider accepts money from the claimant, that provider has violated the law. The workers' compensation law absolutely prohibits taking money from claimants for any medical treatment that is provided under the Act, period." Third Cir. App. at B-155.

case, this Court has consistently held that the enactment and enforcement of an unconstitutional state law is state action. *BMW of North America, Inc. v. Gore*, 517 U.S. 559, 573 n.17 (1996); *Tulsa*, 485 U.S. at 488; *Cohen v. Cowles Media Co.*, 501 U.S. 663, 668 (1991); *NAACP v. Claiborne Hardware Co.*, 458 U.S. 886, 916 (1982); *New York Times*, 376 U.S. at 265; Krotoszynski, *Back to the Briar Patch: An Argument In Favor Of Constitutional Meta-Analysis in State Action Determinations*, 94 Mich. L. Rev. 302, 315 (1994); Strickland, *supra*, 18 Hastings Const. L. Q. at 606.

Under these circumstances, and without using the discrete state action "tests" relied upon by Petitioners, this Court has imposed liability on private persons who either invoke the unconstitutional law to deprive a person of a constitutional right, *See, e.g., New York Times, supra*, or rely on authority granted by the unconstitutional law to deprive a person of a constitutional right. *See, e.g., Tulsa, supra*. In the *New York Times* line of cases, the enforcement of the unconstitutional law occurs in the context of a judicial proceeding, whereas in cases such as *Nixon, Reitman* and *Tulsa* the enforcement of the unconstitutional law is accomplished by a private person or entity pursuant to the terms or authorization of a state statute or state constitutional amendment. When a court enforces an unconstitutional law there is clearly state action, and the private party invoking the unconstitutional law is liable. *New York Times, supra*. On the other hand, when the enforcement of the unconstitutional law is accomplished by a private person or entity pursuant to the terms or authorization of a state law this Court has relied on two distinct but related rationales, neither of which requires application of the discrete "tests", to find private entities liable when invoking the unconstitutional law. Pursuant to *Tulsa*, the private person relying on the unconstitutional law is liable if, after the passage of the act, the state's involvement with the statute is substantial enough to implicate the protections of the Constitution. *Tulsa*, 485 U.S. at 486. This occurs, and state action is present, "when private parties make use of state procedures with the overt and significant assistance of state officials." *Id.* In cases such as *Nixon* and *Reitman*, the Court looked to

whether the state has delegated a state power or function to a private entity or authorized a private entity to do indirectly what the state could not do directly. Instead of applying discrete tests, the Court focuses on the purpose and impact of the state law and holds the private actor accountable for carrying out the state's unconstitutional policy.

The Court's decision in *Tulsa* directly controls this case. That analysis, which would view Petitioners' decision to invoke utilization review and stop medical benefits in the context of the overall statutory scheme, makes it clear that after passage of the Act the state's involvement with the statute was substantial, and that in invoking the unconstitutional provisions of the Act, Petitioners are liable for the violation of Plaintiffs' right to procedural due process.

Pennsylvania's involvement with the statutory process of utilization review is not only extensive, but also much more substantial than the state's involvement with the non-claim statute at issue in *Tulsa*. Like the non-claim statute involved in *Tulsa*, under the Pennsylvania Act the employer's request for utilization review is not self-executing. In order to invoke the statutorily created and state-administrated process of utilization review, and hence to exercise the state authorized power to stop a state entitlement, the employer must first initiate a legal process. This is done by filing a Request for Utilization Review on a form provided by the state with the Pennsylvania Bureau of Workers' Compensation, which is a state agency. Under the Act, while the decision to invoke the statutory process is placed in the hands of the employer, the decision to grant utilization review is retained by the state. If a request is improper or the form is incorrectly filed, the state rejects it and the employer's statutory obligation to provide medical benefits continues. Accordingly, without the overt assistance of the state, the employers have no authority under the Act to stop the medical benefit.

In addition to this overt and significant involvement on the part of state officials in the initiation of utilization review,

the statute directly involves the state, on a day by day basis, in the implementation of the workers' compensation benefit program, and in the enforcement of the employer's decision to seek utilization review. Unlike a private contractual arrangement, absent the state's express authorization, the employers do not have the power or right to deny payment for medical bills that they deem unnecessary or unreasonable. Contrary to the Petitioners' implication that the nonpayment of disputed bills is an accepted business practice, under the Act they are not operating in a private business sphere, but are delivering public benefits which are constitutionally protected from arbitrary deprivations. Accordingly, if the employer fails to file for utilization review or is denied utilization review by the Bureau and attempts to avoid payment of a medical bill that the employer deems unreasonable, the statute authorizes the Bureau's Compliance Division to step in and impose sanctions on the employer. Pursuant to the commands of the statute, the state is therefore involved in policing the employers and in taking aggressive steps to ensure compliance with the Act's terms.

More significantly, an employer's decision to invoke utilization review does not exist in a vacuum, but rather, requires the state's involvement for both approval and enforcement of the decision. The decision to invoke utilization review and to supersede the injured workers' medical benefits is only the first step in what invariably turns out to be a lengthy legal process – a process that is dictated by the state statute, involves the use of state established procedures, state offices and hearing rooms, and state employees at every step of the proceedings.

First, as mentioned above, the initial request for utilization review relies on state forms and requires approval by the Bureau, a state agency staffed by state employees. Employers have no access to the URO outside of this state-created structure. Second, under the statute, in order for the employers to maintain their supersedeas of the injured workers' medical benefits, they must have access to utilization review, which can only be gained through Bureau permission. The state, through the Bureau, is involved in the

approval, training and supervising of the URO's. In addition, the decision on the reasonableness and necessity of the medical treatment in question must be rendered in accordance with the statute, which requires a written report within sixty days of assignment to the URO. The state both supervises and monitors the URO's to ensure compliance with the statute. The state therefore plays an active role by setting standards for the URO's, providing them guidance, and monitoring them to ensure compliance with the statutory requirements. The active role played by the state in relation to the URO's and their decision making process directly involves the state in the utilization review process.

Third, under the Act, the URO's decision can be appealed to a workers' compensation judge, where the injured worker is entitled to a hearing, the right to testify on his behalf, the right to be represented by counsel, and the right to present medical evidence and cross examine the employer's medical expert. The workers' compensation judge is a state employee and the hearing takes place in state facilities. When the proceedings reach this stage, the decision by an employer to invoke utilization review directly involves the state. If the workers' compensation judge rules in favor of the injured worker, it is the state that will revoke the employer's decision to terminate the treatment. If the workers' compensation judge upholds the employer's initial determination to stop the medical benefits, it is the state that will place its imprimatur on that decision, a decision that will have been reached without providing the injured worker any pretermination notice or opportunity to be heard.

The employers' power to stop benefits to injured workers therefore emanates from the state and is dependent upon the state's approval at every key juncture. Without the "overt, significant assistance of state officials", employers would not be able to initiate or sustain the deprivation challenged in this case. *Tulsa*, 485 U.S. at 487.

While *Tulsa* controls this case, Petitioners are also liable for violation of the injured workers' right to procedural due process pursuant to a line of cases that has held that a state may not avoid the strictures of the Constitution by delegating

to private persons or entities the power or authority to do indirectly what the state cannot do directly.[26] *See, e.g., Reitman, supra* at 380-381; *Cf. Lebron*, 513 U.S. at 397. In these circumstances, when the state delegates to private persons or entities a governmental power or function, and the private entity exercises that governmental power or function in a manner that violates a constitutionally protected right, this Court has consistently held that the private person or entity who exercises the governmental power is a state actor. *West*, 487 U.S. at 54; *Evans v. Newton*, 382 U.S. 296, 299 (1966) ("When private individuals or groups are endowed by the state with powers or functions governmental in nature, they become agencies or instrumentalities of the State and subject to its constitutional limitations.").

Two controlling principles emerge from these cases. First, in all of the above cited cases, the authority exercised by the private actor or entity was derived directly from a state statute or constitutional amendment. Without this delegation from the state, the private actor or entity would be powerless to act in the manner prescribed by the statute or state constitutional amendment. *See, e.g., Nixon*, 286 U.S. at 85; *Reitman*, 387 U.S. at 379. The power exercised by the private actor or entity is therefore state power.

Second, in most of the cases, there was at least some indication that by delegating to private actors or entities a

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[26] These cases serve an important purpose in the state action inquiry. Pursuant to the Court's decision in *Tulsa*, state action existed because the state played an overt role in the administration of the statute. However, a state could avoid liability under *Tulsa* by enacting a statute that ceded all state power to the private entity, and in which the state played no role other than enacting the statute. This problem was identified by Justice Stevens dissenting in *Flagg Brothers*, 436 U.S. at 175. In these circumstances, if the state has delegated a state power or function to a private individual or entity in an attempt to avoid the strictures of the Constitution, the above line of cases would still hold the private actor or entity accountable for exercising a state power or function in a manner that violated the Constitution. This prevents the state from doing indirectly what it constitutionally cannot do directly.

state power or function, the state was attempting to evade the strictures of the Constitution, or do indirectly what it constitutionally could not do directly. For example in *Reitman*, the Court placed great weight on the fact that the state supreme court had construed the state constitutional amendment, which was neutral on its face, as authorizing private racial discrimination. *Id.* at 375-76. The state had delegated a power that allowed private individuals to discriminate based on race, something the state could not have done directly. The Court in *Reitman* also noted that, in construing the state amendment to determine whether the delegation was an attempt to evade the strictures of the Constitution, the state court correctly analyzed the law in terms of (1) its immediate objective, (2) the context in which the delegation arose, and (3) the ultimate effect or impact of the delegation. *Id.*; *See also Alliance for Community Media v. F.C.C.*, 10 F.3d at 820.

Applying these principles to the 1993 Amendments, it is clear that Pennsylvania was attempting to evade the strictures of the due process clause by delegating to employers the power to stop or supersede medical benefits without providing pre-deprivation notice or an opportunity to be heard. First, prior to the 1993 Amendments, medical benefits could only be superseded by a state workers' compensation judge after the injured worker had been provided notice and a hearing on the necessity and reasonableness of the treatment. The Amendments delegated to the employers both the state power to initially determine whether the treatment was reasonable and necessary and to stop treatment on that basis.

Second, the state's purpose in delegating this power to the employers was clearly to evade the strictures of the due process clause. The record establishes that the 1993 Amendments were part of a cost containment package ostensibly enacted in order to reduce workers' compensation insurance and thereby attract more business to Pennsylvania. However, in enacting these provisions, the state was aware that it could not directly terminate medical benefits without providing notice or an opportunity to be heard. The 1993 Amendments were not passed in a legal vacuum. Prior to their enactment, almost identical provisions in the Pennsylvania Workers'

Compensation Act had been struck down as unconstitutional. *Baksalary, supra*. It is clear that the state was attempting to harness the energy of the private insurers to carry out the state policy of cost containment and to do indirectly what the state could not constitutionally do directly. The delegation to the employers of the state power to stop or supersede a state entitlement not only violated the state's constitutional duty to provide adequate procedural safeguards, *Logan, supra,* but also made the employers state actors when invoking the unconstitutional procedures. *West, supra*; *Evans, supra*; *Reitman, supra*; *Nixon, supra*. The delegation of the state power of supersedeas to the employers makes this case even more compelling than *Tulsa*. Here, not only was the state substantially involved in the utilization review process, but also, in establishing the utilization review process it was clearly trying to evade "the most solemn obligations imposed" by the due process clause. Pursuant to this Court's decision in *Tulsa* and the above cited delegation cases, Petitioners are clearly state actors.

A. A TOTALITY OF THE CIRCUMSTANCES APPROACH SHOULD BE USED TO FIND STATE ACTION WHERE THERE IS NO FACIAL CONSTITUTIONAL CHALLENGE

1. *Edmonson's* Totality Test

Edmonson was this Court's last major foray into the realm of state action in a case that did not involve a facial challenge to the constitutionality of a state law. The Court's analysis in that case is contrary to the Petitioners' contention that state action can only be established through the rigid application of formulaic rules. Rather, the Court embarked upon a unified state action analysis which took into account 1) the extent to which the actor relies on governmental assistance and benefits; 2) whether the actor is performing a traditional governmental function; and 3) whether the injury caused is aggravated in a unique way by the incidents of governmental authority. *Edmonson*, 500 U.S. at 621-22.

Instead of stating a series of discrete tests and applying them separately to determine whether each by itself was satisfied, the Court considered the facts relevant to these principles and weighed them to determine whether, all things considered, the otherwise private actor fairly could be deemed a state actor. Essentially, the Court adopted a "totality of the circumstances" test.

The approach used by the Court in *Edmonson* is particularly appropriate to discern state action, which in any given circumstance is necessarily a "fact-bound inquiry." For, as this Court has indicated on numerous occasions, "only by sifting facts and weighing circumstances can the non-obvious involvement of the State in private conduct be attributed its true significance". *Lugar v. Edmondson Oil Co*, 457 U.S. 922, 939 (1982). The totality approach relied upon by the Court in *Edmonson* was not a unique or radical departure from the analysis applied in previous state action cases, and was consistent with a number of other decisions in which the Court utilized no specific litmus test, but rather, considered all the facts and circumstances to determine whether the challenged action could be fairly attributed to the state. *See, e.g., West*, 487 U.S. at 55-56; *Tulsa*, 485 U.S. at 479; *see also Burton*, 365 U.S. at 725-26.

The approach used by the Court in *Edmonson*, *West*, and *Tulsa*, its most recent state action cases, is undoubtedly the most reliable method of analysis for discerning state action. The Court has consistently recognized the complexity of the state action inquiry and the factual subtleties which necessarily bear upon the analysis. There is no discrete test which can neatly categorize purportedly private decisions into state action or non-state action pigeonholes. The Petitioners' plea for the adoption of such a test to resolve the "most troublesome issue in constitutional law"[27] is overly simplistic and inconsistent with this Court's most recent pronouncements. It should be rejected. In determining when private conduct can

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[27] Strickland, 18 Hastings Const. L.Q., *supra*, at 588.

be deemed fairly attributable to the state, each situation must be factually analyzed on its own terms.

2. Application of the Totality Test To The Employer's Role in Utilization Review

Application of the *Edmonson* totality approach to the utilization review process at issue here demonstrates that the Third Circuit correctly deemed the employers to be state actors. As this Court has instructed, those procedures and the employers' role in that process must first be viewed in the context of the workers' compensation system as a whole, with its dense web of interconnections between the state agency and the employers who fulfill the state's obligation to Pennsylvania's injured workers. *See* Pet. App. at 25a. *See also West*, 487 U.S. at 56 ("Whether a physician is on the state payroll or is paid by contract, the dispositive issue concerns the relationship among the State, the physician, and the prisoner."). The interconnections between the state and the employers are so numerous and so strong, that a finding of state action is clearly warranted.

a. Governmental Assistance and Benefits

The extent to which the employers rely upon "governmental assistance and benefits" weighs heavily in this case in favor of a finding of state action. The utilization review process is a discrete aspect of the workers' compensation program, one which is established by state law and administered directly by the state for the purpose of delivering public benefits to injured workers without regard to fault. The state acts as a giant funnel through which almost every transaction in the system must pass. The state chooses who the system's participants will be and defines the roles that each will play within the system. The state controls all entrances into and exits from the system and supplies all the rules, regulations, forms, physical offices, hearing rooms, and decision makers. It resolves all disputes as to injured worker eligibility and employer obligations. It is a "system which the government alone administers." *Edmonson*, 500 U.S. at 622.

As in every other context in the Pennsylvania system in which an employer wishes to change the status quo without an injured worker's consent, an employer seeking utilization review must initiate a legal process exclusively administered by the state. Any effort to take a "self-executing" supersedeas, one which is not premised upon a properly submitted request for utilization review, violates the Act and is subject to penalties by the Bureau. Aside from utilization review and the supersedeas of benefits that it permits, and absent consent by an injured worker, a stoppage of medical benefits can only be effectuated by the direct action of state officials. The request for review is only the first step in the utilization review process which intimately involves the state in the determination of the dispute concerning the injured worker's right to medical treatment through a state established procedure. The private decision to seek utilization review and to stop medical benefits, standing alone, cloaks defendants with no authority to interfere in an injured worker's receipt of benefits. The supersedeas cannot be initiated outside of the state's legal framework for utilization review and cannot be maintained without the Bureau's approval.

Thus, the employer's power over an injured worker's continued receipt of medical benefits does not begin and end with a "private" decision to invoke utilization review, as the Petitioners insist. This is not a situation in which a private decision is self-executing and can be carried out without entanglement or interaction with state procedures, state administrative machinery, and state officials. *See, e.g., Tulsa, supra.* The employer's power to supersede benefits emanates directly from the state and is dependent upon the state's approval at every key juncture.

Tulsa reinforces this conclusion. There, the Court rejected the argument that a non-claim statute was self-executing, and held that an executrix's statutory duty to file notice to creditors of the estate constituted state action because it involved the "overt, significant involvement of state officials." *Id.* at 486-87. Central to the Court's holding was the fact that, because the legal proceedings triggered the time bar, the legal proceedings themselves substantially

involved the state in the notice process and rendered the state and the private party joint actors for purposes of the Fourteenth Amendment. *Tulsa*, 485 U.S. at 487. *Accord National Collegiate Athletic Association v. Tarkanian*, 488 U.S. 179, 192 (1988) (state action exists where the "government has created a legal framework for the challenged conduct.").

Here, the decision to stop benefits, standing alone, has no legal effect without an application for admission to the state's utilization review process and approval by state officials. Like the non-claim statute in *Tulsa*, the request for utilization review triggers legal proceedings and within the context of those proceedings, "adversely affects" the injured worker's constitutionally protected interest. 485 U.S. at 491.

b. Traditional Government Function

The second factor identified in *Edmonson* is whether the private actor is engaged in a traditional government function. In the context of the Pennsylvania workers' compensation system, the provision of medical treatment to injured workers, the power to determine whether medical treatment is reasonable and necessary, and the power to stop or supersede those benefits after a determination that the treatment is not reasonable and necessary, have been exclusively within the province of the state. Injured workers must seek medical care for work related injuries through the state, and only through the state. The system is mandatory. Workers cannot opt-out of the system, pay for their own treatment, sue their employers for the cost of their treatment, nor sue the insurers for their failure to provide treatment. Injured workers have no choice but to rely on the state to fulfill its statutory obligation to them.

The constitutional import of this mandatory and exclusive state structure is set forth in *West*. There, the state was under both a constitutional and statutory obligation to provide medical care to inmates housed in state prisons. To fulfill this obligation, the state contracted with a private doctor to provide for medical care. The Court found the doctor to be a state actor because "in the prison context, medical care is the

'exclusive prerogative of the State' ". Thus, the doctor was a "willful participant in joint activity with the State." *Id.*, 487 U.S. at 47.

While Plaintiffs are not prisoners in the sense of *West*, they are nonetheless captives of the state system. Employers and insurers, like the doctor in *West*, are participants in a wholly state-created and administered public benefit system which has a legal obligation to provide medical care to beneficiaries who have no alternative source of such care. Employers and insurers, by virtue of their contract with employers, stand in the same relation to the state and the recipient of medical care as did the doctor in *West*. Here the state guarantees the delivery of medical care to the injured worker by imposing upon the employer the obligation to pay for it, either directly or through a contract of insurance.[28] The provision of workers' compensation benefits in Pennsylvania is, therefore, an exclusive state function.[29]

Power over the process of determining the reasonableness and necessity of medical treatment has historically been exclusively held by the state. Prior to the enactment of the 1993 Amendments, only a workers' compensation judge could make such a determination. *See, infra,* at 7-8. An injured worker's right to medical treatment could not be superseded until notice and a hearing had been provided. Indeed, having created a recognized property interest in medical treatment, the state was under a constitutional obligation to ensure that

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[28] Insurers' curious effort to distance themselves from employers under the Act, by pointing to their "voluntary" participation in the system and their contractual relation with the employer, is unavailing. Having decided to participate in the system, their obligations under the Act are identical to those of the employers. Their not so subtle threat to withdraw from this participation should they be deemed state actors should have no bearing on the state action analysis.

[29] This is not to say that Petitioners are necessarily state actors for all purposes under the Act. Plaintiffs have never made such a claim and the Court does not have to go that far to find that they are state actors in the context of utilization review.

the injured workers' receipt of that benefit was not interrupted without due process. *Logan, supra.*

Utilization review provides a dramatic departure from this practice. It delegates to employers the state's power to determine that treatment is unreasonable and unnecessary and to stop benefits on that basis, and thereby abdicates the state's responsibility to ensure due process in the administration of its public benefit program. The fact that a state delegates to a private party some of its power does not change the governmental character of the power exercised. *Edmonson*, 500 U.S. at 626. When they stop benefits pursuant to utilization review, employers are fulfilling a traditional,[30] if not exclusive, governmental function.[31]

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[30] The insurers' argument that the provision of workers' compensation benefits is not a traditional government function because the benefits are paid by the employer or the insurer, and not the state, misses the mark. The benefits are paid as a result of a statutory entitlement which substituted the no-fault compensation system for the forfeiture of the constitutional right of the employee to sue the employer in tort for workplace injuries. The fact that the state chose to fund the system through an employer mandate rather than an employer tax does not change the character of the benefit or its constitutionally protected status. It is the state through its police power which has conferred the benefit, not the employer. The insurers' analogies to car insurance, therefore, are completely inapposite. Car insurance is a requirement, not an entitlement. Like car insurance, employers are required to carry workers' compensation insurance. As to them, coverage is not a public benefit but a mandatory duty. Employees, however, stand on a completely different footing. Workers' compensation coverage for them is an entitlement and once they are deemed eligible, is one in which they have a constitutionally protected property interest which cannot be divested without due process of law.

[31] For purposes of the *Edmonson* analysis, it is not necessary to engage in the debate over whether the public function must be a traditionally exclusive one. *Edmonson* uses public function as a factor, not a test complete in and of itself, in a totality of the circumstances analysis, and does not address, much less answer, the question whether state action predicated upon a public function test, standing on its own, contains an exclusivity requirement.

c. Aggravation by Unique Incidents of Governmental Authority

Every injured worker receiving workers' compensation benefits is aware that those benefits emanate from the state. Some injured workers' benefits were determined by a workers' compensation judge through an adjudicative process in which the full panoply of state authority has been invoked to establish their entitlement. Their right to receive benefits is set forth in a decision by a workers' compensation judge or a judge from the state's appellate system, and carries with it the prestige and authority of a court order. Those injured workers whose benefits were decided by agreement are aware that those benefits are more than a matter of their employers' grace. Each agreement is documented upon a state form which sets forth the parameters of the injured worker's entitlement and is legally binding. Many of those agreements have been specifically approved by a workers' compensation judge.

The stoppage of benefits without notice or an opportunity to be heard in this context brings with it a betrayal of the trust which emanates from the state's guarantee of medical coverage, memorialized in state documents bearing the name of the Commonwealth of Pennsylvania and the Bureau of Workers' Compensation. The harm caused by the stoppage of benefits through utilization review is aggravated in a unique way by the context in which it occurs. Moreover, it can only occur through a legal framework established by the state itself. When injured workers call the Bureau to find out how their benefits could have been stopped without notice to them or an opportunity to defend themselves, they learn that the state has placed its imprimatur upon the employers' conduct and that they, as purported beneficiaries of the system, are powerless to rectify this injustice.[32] They also learn that the employer

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[32] Indeed, many claimants, including four of the named Plaintiffs, have had their medical benefits stopped through utilization review directly after a Request for Supersedeas hearing which was held within the context of a petition by their employer to terminate, suspend, or modify their benefits and at which a workers' compensation judge has denied

has been delegated authority to interfere with their state-sanctioned benefits without having to show any factual or medical justification. They are forced into, and then trapped in, a state utilization review process in which they are denied any opportunity to speak in their own defense or to have counsel speak on their behalf.

The injured workers' loss under these circumstances is clearly aggravated in a unique way by the mantle of governmental authority which has been bestowed upon their employer to stop their government entitlement. *United States v. Classic*, 313 U.S. 299 (1941). The harm goes beyond human suffering, in the form of physical pain and prolonged and exacerbated disability, to the very root of the due process clause itself, which serves not only to prevent mistaken and arbitrary deprivations of property, but to make the individual so deprived feel that his government has treated him fairly. *Richmond Newspapers, Inc. v. Virginia*, 448 U.S. 555, (1980); *Joint Anti-Fascist Refugee Committee v. McGrath*, 341 U.S. 123, 172 (1951) (Frankfurter, concurring). The deprivation of medical care without notice, with no pre-deprivation opportunity to be heard, and the exclusion of the injured worker from the utilization review process until the appellate stage of review which occurs at the very least, months after the

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supersedeas and ordered that benefits be continued. *See* Jnt. App. at ¶¶ 96-99, 111-113, 147-150, 249-252. Request for supersedeas hearings were put into place by the Consent Decree in *Baksalary* to replace the automatic supersedeas provision invalidated in that case. That the employer can effectively ignore the judge's decision undermines the constitutional remedy which was devised after ten years of litigation in *Baksalary* and justifiably shakes a claimant's confidence and respect for the system and for the authority of the workers' compensation judge who will decide his/her case. A claimant can have little confidence in the fairness of a system in which a supposedly co-equal litigant in the proceedings can vitiate the judge's decision and revoke the benefits the judge has specifically ordered to continue.

medical treatment has been stopped, is inconsistent with these important constitutional principles.[33]

d. The Third Circuit Properly Applied the *Edmonson* Factors

Contrary to the Petitioners' accusation, the Third Circuit's decision, which took into account the totality of the circumstances surrounding the insurers' participation with the state in the provision of workers' compensation benefits generally, and the supersedeas of those benefits which is at the heart of this case, was in accordance with a coherent theory of state action and completely consistent with this Court's decision in *Edmonson*. Far from being miscellaneous irrelevancies, as the Petitioners charge, the factual context used by the court was necessary to place the role of the insurers in the state system in its proper perspective. The picture which emerges when all the relevant factors are considered dictate that the Third Circuit's finding of state action be affirmed.

B. EVEN IF DISCRETE TESTS ARE REQUIRED, THE THIRD CIRCUIT'S STATE ACTION HOLDING AGAINST THE INSURERS SHOULD BE AFFIRMED

1. Joint Participation/Symbiotic Relationship Test

The joint participation/symbiotic relationship test was first identified in *Burton v. Wilmington Parking Authority*, 365 U.S. 715 (1961). There, the Court looked to the many interactions between the state and private restaurant owner who leased space in a state owned facility and attributed particular significance to the fact that both the restaurant and

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[33] Although, since the Third Circuit's Decision, the state has changed its procedures to allow injured workers to submit a personal statement during utilization review, the Petitioners are asking the Court to declare that it would be constitutional, should the state decide to change its procedures, to defer this opportunity until *after* the benefits have been stopped.

the state benefitted economically from the restaurant's decision to practice discrimination. The state and the restaurant were found to be joint participants in the discriminatory activity, notwithstanding the fact that the restaurant chose on its own, without consultation with the state, to discriminate on the basis of race.

The Court has applied this analysis to find state action in other contexts as well. In *Lugar*, for instance, the court found state action in Virginia's prejudgment attachment procedures. There, a creditor executed an *ex parte* affidavit alleging a belief that the debtor might dispose of his property in order to defeat his creditors. That decision was a private one, made without consultation with state officials. Acting on this allegation, the Clerk of the state court issued a writ as a matter of course which was then executed by the County sheriff. The Court held that private use of state procedures with the help of state officials to accomplish a prejudgment deprivation of a constitutionally protected property interest constitutes state action. The Petitioners' emphasis on the fact that they decide to invoke utilization review without consultation with the state is as misplaced and irrelevant here as it was in *Burton* and *Lugar*. For purposes of establishing a symbiotic relationship, the focus is upon the interaction between the state and the employer, the joint motivation underlying the challenged conduct, and the mutual benefit derived by both the state and the employer when the utilization review process is invoked.

Many of the factors set forth in Section III (A)(2)(b), *infra*, under the first *Edmonson* principle, are relevant to whether the employers and insurers act in joint participation with, or in a symbiotic relationship with the state, when they invoke utilization review and stop workers' compensation medical benefits on that basis. The interconnection between the state and the employers in that process is a critical factor in the analysis. No employer may stop benefits without properly invoking the utilization review procedures and enlisting the state to approve its request. Only if that request is granted and the utilization review is permitted can the supersedeas be legally maintained. Thus, this situation is closely akin to the statutory mechanism invalidated in *Lugar*. Here, while the

Bureau employs no sheriffs to assist employers in confiscating the challenged property, the property in dispute, and to which the injured worker presumptively has an entitlement until due process is afforded, is sequestered by the employers with the full knowledge, participation, and imprimatur of state officials.

There is no dispute that the utilization review procedures at issue here were legislated by the state, at the behest of the employers and their insurers, to contain medical costs in the workers' compensation system. The state's policy of cost containment was intended to further its own interest in attracting business to Pennsylvania.[34] To ensure that its own interest was achieved, the statute ensured that employers and their insurers would derive economic benefit directly from the utilization review provisions, who stand to save money each time they invoke the process, whether or not their challenge to the medical treatment under review is ultimately successful.[35]

The state's interest is likewise furthered every time an employer invokes the utilization review procedures and stops benefits. Indeed, if employers did not do so, the interests the state sought to advance through the statute would never be realized. So important to the state is the cost savings to the employers, and so intertwined are the state's and the employers' interests, that the Bureau maintains an office, staffed by state employees, whose specific purpose is to contain the costs of the employers and their insurers.[36] The employer's decision to invoke review in any particular case,

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[34] *See* Third Circuit Brief of Commonwealth Appellees, at 16. *See also* Brief for Petitioners at 44-45.

[35] Because injured workers cannot pay for services pending the review, no matter how legitimate their need for continued treatment or how long the initial review and the appellate process might drag on, there is nothing, in most cases, for the employers to reimburse even if the treatment is ultimately deemed to be reasonable and necessary.

[36] *See* Third Circuit Appendix, Deposition of David Weyl, Chief of Bureau's Cost Containment Unit at B-135, responding to the question, "Whose costs do you contain?": "We are containing the medical costs incurred by employers and insurers, if they have insurers".

therefore, is inevitably intertwined with the state's interest, even though the state is not consulted in advance.

In this situation, therefore, the evidence of joint endeavor by the state and the employers is far stronger than it was in *Burton* or *Lugar*. In *Burton* the state expressed no direct policy interest in the discrimination which was practiced by the restaurant. It was a passive recipient of the increased business generated by the restaurant owner, but there was no evidence that the state was even aware that the restaurant's policy existed. The economic benefit derived by the state through the restaurant's discriminatory conduct was not in furtherance of any expressed policy of the state. The same is true in *Lugar*, where the state provided the procedural scheme utilized by the defendant with the assistance of state officials, but remained neutral as to whether or not the statute was utilized.

Blum v. Yaretsky is not to the contrary. There, the state was not involved in the utilization review process used to assess and diminish the level of care provided to patients within a private nursing home. Although the utilization review was undertaken in accordance with state regulations, and the state was ultimately notified about the action taken by the nursing home and adjusted the payment to the nursing home accordingly, there was absolutely no interaction with the state until the decision to perform utilization review had been made, the review completed, and the ultimate decision as to the appropriate level of care determined. The procedures were entirely self-executing, *i.e.*, they were invoked and utilized by the private nursing home without any state involvement. The activity of the nursing home and the state operated in separate, self-contained spheres which touched, but never intersected. Additionally, in *Blum* there was no challenge to the constitutionality of the procedures themselves. The Plaintiffs in *Blum* never challenged the reduction of their benefit, only the medical decision by their treating doctors as to the level of care they would receive.

This case could not be more different. Here, it is not an institutionally internal medical decision which is being challenged, but the state procedure which permits an employer, in accordance with an express state policy of cost containment, to

override a private doctor's medical decision that treatment is reasonable and necessary. Far from being self-executing, the supersedeas of benefits can be invoked only through an established state procedure which requires interaction between the state and the employer or insurer seeking review. It advances an express policy of the state to benefit both the state and the employers economically. Based on this Court's decisions in *Burton* and *Lugar* there is a symbiotic relationship and joint participation between the state and the employers when benefits are stopped under utilization review.

2. The Public Function Test

The facts set forth in the *Edmonson* public function analysis, *see infra*, at III(A)(2)(b), are sufficient in and of themselves to establish the employers' liability as state actors under the public function test espoused by Petitioners. The only question remaining is whether the power to stop an injured worker's benefits pursuant to utilization review is a function which has heretofore been an exclusive state function, or, more to the point, whether exclusivity ought to be relevant to the analysis at all.

Prior to *Edmonson*, the public function test as articulated by the Court had required that the function delegated to the private party be one traditionally and exclusively performed by the state. *See Flagg Brothers*, 436 U.S. at 157-160. After *Edmonson* much debate ensued as to whether or not the public function test still required exclusivity. *Edmonson* did not use the word "exclusive", a point which was hotly attacked in the dissent. 500 U.S. at 640. Some courts and commentators since *Edmonson* have opined that the exclusivity requirement was eliminated from the public function test, *e.g., Mark v. Borough of Hatboro*, 51 F.3d 1137 (3rd Cir.1995) (Greenberg, concurring); *McKeesport Hospital v. Accreditation Council*, 24 F.3d 519 (3rd Cir. 1994) (Becker, concurring), while others have treated the absence of the exclusivity language in *Edmonson* as a mere oversight on the part of the Court. *E.g., United Auto Workers v. Gaston Festivals, Inc.*, 43 F.3d 902, 906 (4th Cir. 1995); *Gallagher v. Neil Young Freedom Concert*, 49 F.3d 1442 (10th Cir. 1995).

As stated previously, this debate fails to perceive that in *Edmonson*, public function was identified as one of several factors or guiding principles to be utilized in a balancing analysis, not as a "test" which by itself would identify the presence or absence of state action. *See infra*, III(A)(1). Accordingly, it was not necessary to determine whether, if a public function test standing alone exists after *Edmonson*, exclusivity would still be required.

Here, the state has had exclusive control over the stoppage of an injured worker's medical benefits since 1984. Without the consent of an injured worker or an Order of a workers' compensation judge, those benefits were required to continue. Even if exclusivity is required, therefore, Plaintiffs satisfy the test.

The Court has stated, however, that a function does not satisfy the exclusivity test unless it is "traditionally" an exclusive state function. Petitioners respectfully contend that the exclusivity requirement, as articulated in *Flagg Brothers*, is not an element which properly belongs in the public function analysis.

This Court has concluded that to identify the attributes of a traditional governmental function is an impossible task. *Garcia v. San Antonio Metropolitan Transit Authority*, 469 U.S. 528, 544 (1985).[37] To identify one which has been historically exclusive is even more daunting than the task abandoned by the Court in *Garcia*. As the Court observed there, it is impossible to consistently apply such a requirement because what is a traditional or exclusively governmental function has changed as our society has developed. 469 U.S. at 543. Particularly since the New Deal, the government has taken responsibility for many functions which were previously performed by the

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[37] *See also Reitman v. Mulkey*, 377 U.S. at 378 (characterizing as an "impossible task" the formulation of an infallible test for determining whether the state, in any of its manifestations, has become significantly involved in private discriminations).

private sector. To require traditional exclusivity in the public function doctrine would force courts to ignore contemporary experience and would in effect "freeze into law a static conception of Government." *San Francisco Arts and Athletics v. United States Olympic Committee*, 483 U.S. 522, 549 n.1 (1987) (Brennan, *dissenting*). This would permit the exclusion from scrutiny of numerous activities in which the state has exclusively occupied a field of endeavor and then delegated that function to a private entity. Constitutional scrutiny could then be evaded by a private entity, despite its acceptance of a power previously exercised only by the state, if it can point to an earlier time in which the function was privately administered. There would be no limit to how far back a defendant could reach to avoid application of the public function doctrine. In this age of privatization of traditional governmental duties and responsibilities such a result would be unacceptable, as it would allow the state to avoid the strictures of the Constitution by simply ceding its duty and power to a private entity. If the Court maintains a free-standing public function analysis, and within that test an exclusivity requirement, it should deem exclusivity to be satisfied by evidence that the state exclusively occupied a field of endeavor at the time it delegated the function to the private entity.

Even if the Court continues to require traditional exclusivity as part of the public function analysis, however, it would be inappropriate to apply it to this case. Since 1984 in Pennsylvania, the state has exclusively reserved to itself the power to stop an injured worker's medical benefits. Prior to that time, employers were permitted to stop them pursuant to a procedure very like the one at issue here. That provision, however, Section 413 (a) of the Act, was deemed unconstitutional in *Baksalary, supra*. An inflexible application of the exclusivity requirement would permit employers to avoid scrutiny under the public function doctrine because the state, in the past, permitted them to exercise power unconstitutionally.[38] Such a

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[38] The insurers cite to *Silas v. Smith*, 361 F. Supp. 1187 (E.D. Pa. 1973) and *Henderson v. Workers' Compensation Appeal Board*, 69 Pa. 613, 452 A.2d 277 (1982), but fail to disclose that both cases were effectively overruled by *Baksalary*. The consent decree which resulted in that case vested the state with the exclusive right to stop medical benefits.

result should be emphatically rejected, as it would not further the goals of the public function analysis, and would surely produce a constitutional anomaly.

3. Government Compulsion and Encouragement

The third "test" relied upon by the Petitioners is the government compulsion test. This argument is somewhat disingenuous because the Court has never required compulsion to find state action. If the state has provided such significant encouragement, either overt or covert, that the choice exercised by the private actor must be deemed in law to be that of the state itself, state action is present. *Blum v. Yaretsky*, 457 U.S. 991, 1004 (1982); *Jackson v. Metropolitan Edison Company, supra*.

Plaintiffs do not disagree that state encouragement or compulsion requires more than intensive state regulation. They have never contended that the insurers, who, to be sure, are extensively regulated by the state, are state actors for that reason alone. *Blum, supra*; *Moose Lodge No. 107 v. Irvis*, 407 U.S. 163 (1972).

In order to escape the appearance of any nexus to the state, Petitioners attempt to place the decision to invoke utilization review in a vacuum, as if it were that decision alone, outside of the state's established system for review of reasonableness and necessity of medical treatment, which causes the harm of which the Plaintiffs complain in this case.

While it is true that the state does not preview each request for utilization review, the statutory scheme clearly encourages the use of the utilization review process and the supersedeas of benefits which it authorizes. The Act prohibits an employer from unilaterally stopping an injured worker's medical benefits except in the context of utilization review. By granting them the power to stop benefits in that unique

context, the state is furthering its expressed policy of cost containment.

This Court has recognized that state encouragement of an ostensibly private decision may take subtle forms. In *Reitman, supra*, for instance, the Court found state action on the part of an individual who had used a facially neutral state constitutional amendment which had the purpose and effect of authorizing, but not mandating, racial discrimination in the housing market. The Court looked to the immediate objective of the legislation, the ultimate effect, and the historical context to determine that the state was using the amendment to encourage private discrimination, something which it could not do directly. By deputizing private citizens to advance the state's agenda, the individuals who carried that agenda forward through their use of the amendment became state actors.

The Amendments at issue here, which permit, but do not require, the insurers to stop an injured worker's state entitlement to medical benefits without notice or an opportunity to be heard, had the purpose and effect of encouraging the insurers to do indirectly what the state could not do directly, that is, to stop injured workers' access to medical care without pre-deprivation process. The immediate objective of the legislation was to contain costs in the state's workers' compensation program. To achieve the objective of this express state policy, the state enlisted employers and insurers to advance its purpose. It focused the attention of the employers on the reasonableness and necessity of medical treatment, the direct target of the state's cost containment effort, and permitted employers to stop those benefits through the utilization review process, and only that process.[39] It imposed no criteria to protect an injured worker from the arbitrary stoppage of his benefits and ensured that the consequences to the employer

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[39] Thus, here there is even more evidence of state action than was present in *Reitman*, because there, the individual was free to discriminate on any ground he chose. *See Alliance for Community Media v. FCC, supra*, (applying *Reitman* analysis to find government encouragement of suppression of indecent material, something which the government could not do directly, through the acts of private cable operators).

for erroneous or unfounded use of the process would be minimal, by precluding an injured worker from securing the challenged treatment pending review.[40] In short, by invoking utilization review, the insurer had everything to gain and nothing to lose, a fact which was sure to encourage widespread use of the process. Indeed, by January of 1995, when this case was filed, and just sixteen months after the law went into effect, more than 40,000 requests for utilization had been filed. Jnt. App. at 16.

Unlike this case, in which the state had an express policy of cost containment which it advanced by deputizing employers to stop medical benefits, the cases cited by the Petitioners to avoid a finding of state encouragement or compulsion are inapposite. In *Jackson*, for instance, while the private utility had been granted a monopoly and was a heavily regulated business, the state had no policy, rule, or procedure concerning the termination of services. The state's regulation of the utility was unrelated to the transaction which gave rise to the constitutional dispute. *Accord Rendell-Baker v. Kohn, supra* (regulation imposed by the state upon the private school was unrelated to the personnel action which formed the basis of the constitutional challenge). Additionally, the decision to terminate services was self-executing and did not require the participation of state officials. In terminating services, the utility was not exercising any authority or power delegated by the state.

Likewise, in *Flagg Brothers*, the only state involvement was the passage of a statute that regulated private conduct. The state provided a mechanism for resolution of private disputes but had no contact whatsoever with the private parties who used it. The statute was wholly self-executing and the state was completely neutral as to whether the procedures

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[40] The insurers' and the DOJ's observation that the 10% penalties discourage arbitrary use of the process is disingenuous at best, since 10% of nothing is 0. Unless an injured worker can convince her medical provider to treat him gratuitously during the review process, which can take years to complete if appeals are involved, the injured worker is precluded from generating bills which would call for reimbursement.

were utilized. It did nothing to encourage the use of those procedures and derived no benefit from their use.

Here the state procedures under challenge were designed to and did in fact encourage the employers to interfere in the injured workers' property interest in the receipt of medical treatment. The fact that employers voluntarily used those procedures without advance consultation with the state, something upon which the state depends for the advancement of its cost containment agenda, does not diminish the state's role in the employer's conduct, but rather, increases it.[41] Employers in this context are state actors.[42]

CONCLUSION

For all the reasons stated herein, Respondents respectfully urge the Court to affirm the decision of the Court of Appeals for the Third Circuit.

Respectfully submitted,

**LORALYN McKINLEY*
McKinley and Vonier
1333 Race Street
Philadelphia, PA 19107
(215) 569-1644

Counsel for Delores Scott Sullivan, William Battle, Anthony Cancila, Louis Baumgartner, and Class Plaintiffs

ALAN B. EPSTEIN
Jablon Epstein
A Professional Corporation
The Bellevue, Ninth Floor
Broad Street at Walnut
Philadelphia, PA 19102-3803
(215) 790-0300

Counsel for Charles Matthews, Christopher Costello, Lisa Lex, Susan Hansen, Terrance Ervine, William C. Dillon, and Class Plaintiffs

**Counsel of Record*

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[41] *See Reitman*, 387 U.S. at 381-87 (Douglas, concurring); *see also Alliance Media, supra*, 10 F.3d at 822 n.13.

[42] Plaintiffs note that the Petitioners rely upon numerous facts and statistics which were not in the record in the district court. It must be remembered that Plaintiffs' due process challenge was dismissed pursuant to a motion under 12(b)(6) of Federal Rules of Civil Procedure. Thus, the facts as Plaintiffs have alleged them govern the analysis of this case.

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In the Supreme Court of the United States

OCTOBER TERM, 1998

AMERICAN MANUFACTURERS MUTUAL INSURANCE COMPANY, ET AL., PETITIONERS

v.

DELORES SCOTT SULLIVAN, ET AL.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE SUPPORTING PETITIONERS

SETH P. WAXMAN
Solicitor General
Counsel of Record
FRANK W. HUNGER
Assistant Attorney General
EDWIN S. KNEEDLER
Deputy Solicitor General
JEFFREY A. LAMKEN
Assistant to the Solicitor General
BARBARA C. BIDDLE
JACOB M. LEWIS
Attorneys
Department of Justice
Washington, D.C. 20530-0001
(202) 514-2217

37pp

QUESTIONS PRESENTED

1. Whether a private insurer's decision to defer payment of medical bills pursuant to the utilization review provisions of Pennsylvania's Workers' Compensation Act, Pa. Stat. Ann. tit. 77, § 531(5), (6) (West Supp. 1998), constitutes "state action" under the Fourteenth Amendment.

2. Whether the insurer's decision to withhold payment of medical bills without first providing the employee with an opportunity to submit a written statement violates due process.

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Cases—Continued: Page

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Lebron v. *National R.R. Passenger Corp.*, 513 U.S. 374 (1995) 12
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In the Supreme Court of the United States

OCTOBER TERM, 1998

No. 97-2000

AMERICAN MANUFACTURERS MUTUAL INSURANCE COMPANY, ET AL., PETITIONERS

v.

DELORES SCOTT SULLIVAN, ET AL.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE SUPPORTING PETITIONERS

INTEREST OF THE UNITED STATES

The court of appeals held that (1) private workers' compensation insurers are state actors insofar as they choose to defer the payment of medical bills pursuant to the utilization review provisions of the Pennsylvania Workers' Compensation Act, and (2) such decisions violate due process if made without first obtaining a written statement from the affected employee.

The United States administers a number of programs in which the decisions of private participants affect payments and services to individuals, and is generally interested in the faithful application of the state action requirement and due process principles. The Department of Labor administers the Longshore and Harbor Workers' Compensation Act (LHWCA), 33 U.S.C. 901-950, which establishes a system of workers' compensation for those engaged in maritime employment. Under Section 14(c) of that Act, 33 U.S.C. 914(c), an employer that voluntarily pays LHWCA compensation to an employee in the absence of a formal compensation award is permitted to suspend or terminate those payments with-

out a prior hearing; the employer need only file a timely notice of that action with the Department. 20 C.F.R. 702.234-702.235. That provision is currently the subject of a constitutional challenge similar to the one at issue here. See *Kreschollek* v. *Southern Stevedoring Co.*, No. 93-3903 (D.N.J. Sept. 30, 1997). In addition, utilization review with regard to medical determinations has historically been part of the Medicare Program. See, *e.g.*, 42 U.S.C. 1395cc. Similar state action and due process questions have arisen in connection with health maintenance organization decisions respecting the provision of medical services to individuals covered by the Medicare Program, 42 U.S.C. 1395 *et seq.* See, *e.g.*, *Grijalva* v. *Shalala*, 152 F.3d 1115 (9th Cir. 1998).

STATEMENT

1. Beginning in the early twentieth century, numerous state legislatures concluded that the common law was inadequate to address liability and compensation issues arising from the increasingly frequent and severe work-related injuries that accompanied industrialization. See *New York Cent. R.R.* v. *White*, 243 U.S. 188, 197 (1917) (discussing perceived faults in common-law system); 1 A. Larson, *Larson's Workers' Compensation Law* §§ 5.20-5.30, at 2-15 to 2-25 (1998). As a result, by 1920 most States had enacted workers' compensation laws—laws that require employers to compensate their employees for work-related injuries without regard to fault and without regard to the common-law doctrines that previously barred liability. See generally 1 A. Larson, *supra*, § 5.30, at 2-25.

Pennsylvania's Workers' Compensation Act, Pa. Stat. Ann. tit. 77, §§ 1 *et seq.* (Act or Pa. Stat.), first enacted in 1915, follows that model, replacing traditional tort remedies with an exclusive system of no-fault liability for work-related injuries. 77 Pa. Stat. §§ 431, 481(a) (Supp. 1998). All employers subject to the Act must purchase workers' compensation insurance—from a private insurer or from the

State Workers' Insurance Fund (SWIF)—or obtain permission from the State to self-insure. 77 Pa. Stat. § 501(a) (Supp. 1998).

When an employee is disabled by a work-related injury—and liability under the Act is not contested or no longer at issue, Pa. Code §§ 127.404(b), (c), 127.405(a) (1998)—the employer or its insurer must pay "for reasonable surgical and medical services," and do so "within thirty (30) days of receipt of [the] bills." 77 Pa. Stat. § 531(1)(i), (5) (Supp. 1998). If the "employer or insurer disputes the reasonableness or necessity of the treatment provided" for a covered injury, however, it may defer payment and file a request for "utilization review" with the Workers' Compensation Bureau of the Pennsylvania Department of Labor and Industry (Bureau). *Id.* §§ 531(5), (6)(i) (Supp. 1998); 34 Pa. Code § 127.208(e).

When such a request is filed, utilization review is conducted by authorized "utilization review organizations" (UROs), private organizations consisting of "impartial" healthcare providers, 77 Pa. Stat. § 29 (Supp. 1998), who are "licensed in the same profession and hav[e] the same or similar specialty as that of the provider of the treatment under review," *id.* § 531(6)(i) (Supp. 1998); 34 Pa. Code § 127.466. The only issue addressed in utilization review is "whether the treatment under review is reasonable or necessary for the medical condition of the employee" in light of "generally accepted treatment protocols." 34 Pa. Code §§ 127.470(a), 127.467. Reviewers must "assume the existence of a causal relationship between the treatment under review and the employe[e]'s work-related injury," and "may not consider or decide issues such as whether the employe[e] is still disabled, whether maximum medical improvement has been obtained, quality of care or the reasonableness of fees." *Id.* §§ 127.470(b), 127.406.

Reviewers must examine the treating provider's medical records, 34 Pa. Code §§ 127.459, 127.460, and are required to

give the treating provider an opportunity to discuss the treatment under review, *id.* § 127.469. The URO may not request (and the insurer, employer, employee, and physician alike are all forbidden from supplying) any "reports of independent medical examinations." *Id.* § 127.461. If the URO determines that the treatment is reasonable or necessary, the employer or insurer must pay the disputed bill, with interest computed at an annual rate of ten percent, even if the insurer or employer seeks further review. 77 Pa. Stat. § 717.1(a) (Supp. 1998); 34 Pa. Code §§ 127.208(f), 127.210(d), 127.479. In addition, the employer or insurer is required to pay the cost of utilization review, whether or not its position is sustained. 77 Pa. Stat. § 531(6)(iii) (Supp. 1998). UROs are required to issue a written report of their findings within 30 days of a request, *id.* § 531(6)(ii) (Supp. 1998), and usually do so within 70 days, Pet. 5.

Any party that disagrees with the URO's determination may seek a determination from the Bureau within 30 days.[1] The matter is then assigned to a workers' compensation judge, who may hold a hearing, for a de novo determination of reasonableness or necessity. 77 Pa. Stat. § 531(6)(iv) (Supp. 1998); 34 Pa. Code § 127.556. If payment is required following utilization review but the judge later rules in favor of the employer or insurer, the employer or insurer may recover the excess payments from the Workmen's Compensation Supersedeas Fund, which is financed by annual assessments on insurers and self-insurers subject to the Act. 34 Pa. Code § 127.208(f); see 77 Pa. Stat. § 999(a), (b). An employee who prevails before a workers' compensation judge is entitled to costs and attorney's fees if the employer or

[1] Previously, Pennsylvania law permitted a party dissatisfied with a URO determination to file for reconsideration by another URO before seeking a determination by a workers' compensation judge. That additional layer of review was eliminated in 1996. See Pet. App. 8a-9a, 64a-65a.

insurer fails to demonstrate a reasonable basis for contesting the bill. 77 Pa. Stat. § 996 (Supp. 1998).

2. Respondents are ten individual employees and two organizations representing employees who have been found to be disabled under the Pennsylvania Workers' Compensation Act, and who claim that payment of particular medical bills was deferred under the Act in violation of their due process rights. See J.A. 25-42 (Complaint). They filed suit in federal district court under 42 U.S.C. 1983 against a number of private insurance companies who provide workers' compensation insurance in Pennsylvania, as well as the School District of Philadelphia (which self-insures), various Pennsylvania officials who administer the Act, and the director of the SWIF.

After limited discovery, Pet. App. 47a-48a n.1, the district court dismissed the private insurance company defendants from the case on the ground that they are not state actors. *Id.* at 59a. The court explained that "the decision to cease paying medical benefits" under the Act "is entirely up to the insurer acting independent of any state involvement whatsoever." *Ibid.* Moreover, the court emphasized, "[t]he state takes no substantive step to promote, support or encourage" the insurer's decision, and "after the decision is made, the state takes no action which influences the ultimate substantive determination as to whether benefits are payable or not." *Ibid.*

The district court later dismissed the claims against the state defendants on the ground that the Act does not violate respondents' due process rights. The court held that respondents have a constitutionally protected property interest in their workers' compensation medical benefits, Pet. App. 68a, but, applying the three-part test set forth in *Mathews* v. *Eldridge*, 424 U.S. 319, 335 (1976), concluded that the Act provides adequate process. Pet. App. 69a-75a. The court observed that, while respondents' interest in avoiding interruption of their medical benefits is "without a doubt signifi-

cant," *id.* at 70a, that interest is "adequately protected by the procedures in place," *id.* at 71a. The risk of erroneous decisions, the court found, is "minimal" because the Act requires utilization review to be "based on a medical determination" grounded in the treating physician's testimony and medical records. *Id.* at 72a. The court also emphasized the government's interest in controlling the "high costs of medical treatment" and "the corresponding high cost of insurance" under the Act. *Id.* at 75a.

3. The court of appeals reversed both rulings. Pet. App. 1a-37a. The court acknowledged that "insurance companies are private entities," but it held that "when they act under the construct of the Workers' Compensation system, they are providing public benefits which honor State entitlements." *Id.* at 14a-15a. "In effect," the court stated, the insurers "become an arm of the State, fulfilling a uniquely governmental obligation under an entirely state-created, self-contained public benefit system." *Id.* at 15a. In the court's view, Pennsylvania "is intimately involved in any decision by an insurer to terminate an employee's constitutionally protected benefits because an insurer cannot suspend medical payments without first obtaining authorization from the Bureau." *Ibid.* Because "[t]he Act mandates compliance by employers, employees, and insurance companies and inextricably entangles the insurance companies in a partnership with the Commonwealth such that they become an integral part of the state in administering the statutory scheme," the court concluded that "the private insurers are state actors." *Id.* at 19a.

Addressing the due process issue under *Mathews* v. *Eldridge*, the court of appeals found "the employees' private interest in receiving uninterrupted medical benefits" to be "a weighty and significant factor in the pretermination calculus." Pet. App. 28a. The court acknowledged that "the Act does not proscribe a medical provider from continuing to treat an employee during the utilization review process," but

assumed that "medical benefits are typically terminated upon invocation of utilization review." *Id.* at 27a. "Although a monetary award may compensate an individual for financial losses," the court observed, "a monetary award cannot be deemed an adequate * * * substitute for relieving an employee's disability or pain," or for "necessary medical care." *Id.* at 28a.

The court of appeals also found the risk of erroneous deprivation to be "significant." Pet. App. 29a. Recognizing that the utilization review process affords the employee's physician an opportunity to discuss the employee's treatment, the court nonetheless found itself "hard-pressed to believe that the portrait of the employee's illness and treatment is complete without a statement or other input from the employee himself." *Ibid.* The court acknowledged that the government has legitimate interests in ensuring that only "reasonable and necessary medical treatment[s]" are reimbursed and "in containing the rising costs of medical care and insurance payments," *id.* at 29a-30a, but it was "not convinced that any governmental interest outweighs the private interest" in favor of further process. *Id.* at 30a. The court therefore concluded that, before payments are "suspended" pending or through utilization review, a disabled employee must be given "an opportunity and time to submit a personal statement in writing regarding the employee's view of the reasonableness and/or necessity of the disputed medical treatments." *Id.* at 33a.[2]

SUMMARY OF ARGUMENT

1. The actions of private parties will ordinarily be attributed to the State for purposes of the Fourteenth Amend-

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[2] The court of appeals also identified a number of deficiencies in the notice provided to employees. Pet. App. 21a-25a, 33a. Following its decision, the State modified the notice provided to employees, and petitioners do not challenge the court of appeals' holding regarding notice. Pet. 22 n.12.

ment only when the parties have wielded uniquely governmental authority delegated to them by the State, or the State "has provided such significant encouragement" that the private decision "must in law be deemed to be that of the State." See, *e.g.*, *Blum* v. *Yaretsky*, 457 U.S. 991, 1004-1005 (1982). In this case, the Pennsylvania Workers' Compensation Act requires private insurers to pay the medical bills of a disabled employee within 30 days of receipt, unless the insurer challenges the reasonableness and necessity of the treatment by filing a request for utilization review. The Act does not, however, confer upon insurers a power traditionally entrusted to government; on the contrary, it limits an insurer's power, which pre-dated the Act, to suspend payment pending resolution of a contractual dispute. Nor does the Act, by requiring prompt utilization review, so significantly encourage insurers to suspend payments that their decision to do so must be attributed to the State. State law does not require insurers to challenge the reasonableness or necessity of any medical treatment, or to suspend payments when they do so. Indeed, there are distinct disincentives to seeking utilization review. The insurer must pay the costs of the review, pay any bills that are found to be reasonable or necessary in review (plus interest at an annual rate of ten percent), and subjects itself to potential liability for a prevailing employee's litigation costs (including attorney's fees) if a workers' compensation judge ultimately rules in favor of the employee. The most that can be said is that deferring payment of medical bills is an option for insurers that Pennsylvania law does not prohibit. But "[m]ere approval of or acquiescence in" private initiatives "is not sufficient to justify holding the State responsible for those initiatives under the terms of the Fourteenth Amendment." *Blum*, 457 U.S. at 1004-1005.

2. The Pennsylvania workers' compensation scheme provides constitutionally sufficient process. As an initial matter, respondents do not have a "property" interest in the

payment of bills before the propriety of those bills has been resolved. Respondents are mere applicants for payment, and lack an established entitlement to the funds they seek. Respondents may have a property interest in their *claims* for payment. But deferring payment pending utilization review does not deprive respondents of their claims. After review is conducted, respondents may still assert their claims for payment by presenting them to the Bureau for adjudication before a workers' compensation judge. Because deferring payment for a reasonable period thus does not deprive respondents of property in which they have a cognizable interest, it is not inconsistent with the Fourteenth Amendment.

In any event, Pennsylvania law accommodates both the employee's interest in payment for reasonable and necessary medical expenses, and the insurer's interest (as well the State's) in ensuring that unreasonable and unnecessary treatment is not reimbursed. Pennsylvania limits the insurer's ability to withhold payment to those situations in which it challenges the reasonableness and necessity of medical treatment, and provides prompt review of insurer decisions by impartial healthcare providers of an appropriate specialty. That review includes examination of the treating provider's records and discussions with the provider. It is difficult to see how that prompt review—which by law must take place within 30 days and in practice takes about 70 days—is insufficient for due process purposes when the employee, if dissatisfied with the decision, may then seek review by the Bureau and demand a de novo hearing before a workers' compensation judge.

The principal requirement added by the court of appeals—that payments not be deferred until the employee is heard in the utilization review process—would not enhance the system's accuracy. Because utilization review is based on medical judgments, it is unclear what the employee, who has no medical training, might add that his treatment provider

cannot. Requiring employee participation, moreover, would threaten the streamlined nature of utilization review, and prohibiting the deferral of payments until after utilization review would virtually destroy the system's cost-containment purpose. As this Court has recognized, see *Mathews* v. *Eldridge*, 424 U.S. 319, 347 (1976), there are substantial real-world difficulties associated with the recovery of excess payments from individual claimants. Without a means for postponing payment pending at least initial review, bills for unreasonable and unnecessary treatment would irretrievably be paid. Pennsylvania has determined that so doing imposes unacceptable costs on the workers' compensation system and on employers and insurers generally. It was not for the court of appeals to second-guess that reasonable legislative determination.

ARGUMENT

I. A DECISION BY A PRIVATE INSURER TO DEFER PAYMENT PENDING UTILIZATION REVIEW IS NOT STATE ACTION

The Fourteenth Amendment's prohibition against deprivations of property without due process applies only to actions that are properly attributable to the State. See, *e.g.*, *NCAA* v. *Tarkanian*, 488 U.S. 179, 191 (1988); *Jackson* v. *Metropolitan Edison Co.*, 419 U.S. 345, 349 (1974).[3] This Court has repeatedly acknowledged the importance of this state action requirement, because it both "preserves an area of individual freedom by limiting the reach of federal law and federal judicial power" and "avoids imposing on the State,

[3] In addition, 42 U.S.C. 1983, under which respondents brought suit, is limited to deprivations of constitutional rights "under color of" state law. Where deprivations of rights under the Fourteenth Amendment are concerned, however, "the under-color-of-state-law requirement does not add anything not already included within the state-action requirement of the Fourteenth Amendment." *Lugar* v. *Edmondson Oil Co.*, 457 U.S. 922, 935 n.18 (1982).

its agencies or officials responsibility for conduct for which they cannot fairly be blamed." *Lugar* v. *Edmondson Oil Co.*, 457 U.S. 922, 936 (1982).

In recent cases, the Court has articulated two prerequisites to a finding of "fair attribution." *Lugar*, 457 U.S. at 937. First, the challenged deprivation must "be caused by the exercise of some right or privilege created by the State or by a rule of conduct imposed by the State or by a person for whom the State is responsible." *Ibid.* Second, "the party charged with the deprivation must be a person who may fairly be said to be a state actor." *Ibid.* Accord *Edmonson* v. *Leesville Concrete Co.*, 500 U.S. 614, 620 (1991); *West* v. *Atkins*, 487 U.S. 42, 49 (1988).

In this case, Pennsylvania limits the ability of a private workers' compensation insurer to defer payment of a medical bill by compelling payment within 30 days unless the insurer files a request for utilization review, and by compelling payment thereafter if the insurer's position is not sustained in utilization review. 77 Pa. Stat. § 531(5), (6) (Supp. 1998). But the statute's *restrictions* on the ability of private insurers to defer payment pending a challenge to the reasonableness or necessity of treatment is not challenged in this case. No party contends that Pennsylvania lacks the power to impose those restrictions on insurers. Instead, respondents' contentions center on the decisions of insurers, within those restrictions, to defer the payment of medical bills pending utilization review, an action that the State neither prohibits nor requires. The question before the Court is whether that decision to withhold payments—made by concededly privately owned and controlled institutions, Pet. App. 15a; see Pet. ii-iii[4]—can be fairly attributed to the State. In our view, the answer is "no."

[4] By contrast, the State Workers' Insurance Fund (SWIF) is established and administered by the State. See 77 Pa. Stat. § 2604 (Supp. 1998). The court of appeals assumed (Pet. App. 12a) that SWIF is a state actor

A. Although this Court has not followed an unwavering line in its state-action determinations, "certain principles of general application" emerge. *Edmonson*, 500 U.S. at 621. Thus, for example, the State "normally can be held responsible for a private decision only when it has exercised coercive power or has provided such significant encouragement, either overt or covert, that the choice must in law be deemed to be that of the State." *Blum* v. *Yaretsky*, 457 U.S. 991, 1004 (1982); accord *San Francisco Arts & Athletics* v. *United States Olympic Comm.*, 483 U.S. 522, 546 (1987); *Rendell-Baker* v. *Kohn*, 457 U.S. 830, 840 (1982). Similarly, state action may be found where a private entity exercises functions that are "traditionally the exclusive prerogative of the State." *Jackson*, 419 U.S. at 353; accord *San Francisco Arts & Athletics*, 483 U.S. at 544. As this Court summarized in *Edmonson*, the Court normally looks to "the extent to which the actor relies on governmental assistance" in effectuating its will, "whether the actor is performing a traditional governmental function," and "whether the injury caused is aggravated in a unique way by the incidents of governmental authority." *Edmonson*, 500 U.S. at 622. None of those factors suggests that insurer decisions to defer payment of medical bills, pending further review, constitute state action here.

1. Respondents do not assert that the State "exercise[s] coercive power" or "significant[ly] encourage[s]" private insurers to withhold payment of bills pending further review. *Blum*, 457 U.S. at 1004. Nor could they. As the court of appeals recognized (Pet. App. 5a), the Act permits but does not require an insurer to defer payment pending resolution of a request for utilization review. See 77 Pa. Stat. § 531(5)

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for purposes of the Fourteenth Amendment and that SWIF acts under color of state law within the meaning of 42 U.S.C. 1983. See *Lebron* v. *National R.R. Passenger Corp.*, 513 U.S. 374, 400 (1995). Because SWIF is not a petitioner in this Court, its status is not at issue here.

(Supp. 1998). Indeed, far from providing "significant encouragement" to withhold bills, *Blum*, 457 U.S. at 1004, the State restricts the ability of insurers to do so, and provides distinct disincentives as well.

Thus, insurers are required to pay medical bills within 30 days, except when they dispute the reasonableness or necessity of the treatments. 77 Pa. Stat. § 531(6) (Supp. 1998); 34 Pa. Code § 127.452. An insurer may not defer payment based on challenges to the employee's disability, belated concerns about the cause of the injury, or disputes over the size of the fee. Moreover, if an insurer does withhold payment based on a challenge to reasonableness or necessity, that decision is promptly subjected to utilization review, and the insurer must bear the cost of the review, regardless of the outcome. 77 Pa. Stat. § 531(6)(iii) (Supp. 1998). In the event the URO determines that the medical treatment was reasonable or necessary, the insurer must pay the bill immediately, plus interest at an annual rate of ten percent. 77 Pa. Stat. § 717.1(a) (Supp. 1998); 34 Pa. Code § 127.210(d). And, if the matter comes before a workers' compensation judge, the insurer may ultimately be liable not only for interest, but for attorney's fees and costs as well. 77 Pa. Stat. § 996 (Supp. 1998). Given those distinct restrictions and disincentives, it cannot be said that the State compels, or even encourages, an insurer to defer payment of a particular claim pending utilization review.

2. Nor can it be said that insurers, in withholding payments pending utilization review, exercise a delegated "power[] traditionally exclusively reserved to the State." *Jackson*, 419 U.S. at 352. This case does not involve the running of an election. Contrast *Smith* v. *Allwright*, 321 U.S. 649, 663 (1944). It does not involve the governance of a city or town. Contrast *Marsh* v. *Alabama*, 326 U.S. 501 (1946). Nor does it involve the selection of jurors who serve the governmental function of conclusively resolving legal disputes. See *Edmonson*, 500 U.S. at 624 (selection of jury, "a quin-

tessential governmental body, having no attributes of a private actor," is state action, where a state actor (the judge) impanels and dismisses the jurors). Rather, it involves the sort of uniquely private decision that insurers of all varieties —and members of the public generally—must make on a regular basis: whether to pay a bill submitted for payment, or instead to withhold payment and dispute the bill.

Under our system of ordered liberty, it is normally the individual seeking to obtain property from another who bears the burden of invoking the State's adjudicatory machinery and coercive powers to compel transfer; rare is the system that compels private individuals to transfer property to another first, and litigate the propriety of transfer later. Thus, if an employer had entered into a contract to insure against claims for reasonable or necessary medical expenses by injured employees *before* Pennsylvania enacted its workers' compensation statute, the insurer could have refused to pay a bill (based on a disagreement as to its reasonableness or necessity) without calling upon the State's authority to do so.[5] Under that scenario, it would be clear that the private insurer has not engaged in state action, because the State would have no involvement whatsoever in the insurer's decision to withhold payment of the disputed bill. For the same reason, an insurer's decision to defer payment in conformity with the Pennsylvania Workers' Compensation Act—which merely preserves (in part) the pre-existing power of insurers to defer payment—is not state action either.

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[5] See *Silas* v. *Smith*, 361 F. Supp. 1187, 1194 (E.D. Pa. 1973) ("Absent a statute, the party required by the terms of the agreement to make the payments had the power to stop making those payments whenever it felt they were no longer required under the terms of the agreement."); *Henderson* v. *Workmen's Compensation Appeal Bd.*, 452 A.2d 277, 279 (Pa. Commw. Ct. 1982) ("[I]f the Act did not exist, the employer would be free to stop payments if it determined that the employee's disability had ended.").

Of course, Pennsylvania has departed somewhat from the usual model by limiting the right of insurers to defer payment of disputed bills, and by adding strong incentives against so doing. See p. 13, *supra*. Respondents' complaint, however, is not that the Commonwealth has restricted the insurers' ability to defer payment, but rather that it has not restricted that ability enough, because it does not require insurers to pay bills pending utilization review and the employee's participation therein. Consequently, as in *Flagg Brothers, Inc.* v. *Brooks*, 436 U.S. 149, 166 (1978), "the crux of [the] complaint" here "is not that the State *has* acted, but that it has *refused* to act." A State's refusal to act, however—and its refusal to compel the payment of disputed bills in advance of their resolution—does not constitute "state action" under the Fourteenth Amendment, even if the State announces in advance "the circumstances under which" it "will not interfere with private" decisions. *Ibid.*; see also *Blum*, 457 U.S. at 1004-1005 (mere "approval of or acquiescence in the initiatives of a private party" is insufficient).

This Court's decision in *Flagg Brothers* is thus highly instructive. There, the plaintiff argued that a warehouseman's proposed sale of stored goods pursuant to New York's commercial code could be properly attributed to the State. But, as the Court explained, the New York statute did "nothing more than authorize (and indeed limit)—without participation by any public official—what Flagg Brothers would tend to do, even in the absence of such authorization, *i.e.*, dispose of respondents' property in order to free up its valuable storage space." 436 U.S. at 162. The Court observed that the State's provision of a "system of rights and remedies, recognizing the traditional place of private arrangements in ordering relationships in the commercial world," did not "delegate[] to Flagg Brothers an exclusive prerogative of the sovereign." *Id.* at 160. In similar fashion, the Pennsylvania Workers' Compensation Act merely fails to eliminate the ability of private insurers to act as they "would

tend to do," *i.e.* defer payment of disputed bills, "even in the absence of" its provisions. *Id.* at 162. As a result, it does not constitute a delegation of traditionally exclusive state powers.

3. Finally, it cannot be said that the injury asserted by respondents "is aggravated in a unique way by the incidents of governmental authority." *Edmonson*, 500 U.S. at 622. This is not a case involving the sort of dignitary harm—such as that caused by racial discrimination—that can be exacerbated by an appearance of governmental endorsement. See *id.* at 628 (injury from racially-discriminatory conduct is aggravated where it is effectuated by public officials in a public building that constitutes a "real expression of the constitutional authority of the government"); see also *Shelley* v. *Kraemer*, 334 U.S. 1, 19-22 (1948). Instead, this is a case about a commercial dispute—a contest between a private insurer, which has temporarily withheld payment, and an injured employee, who demands immediate payment—in which the government has initially declined to take part. In such a case, there can be no "unique" aggravation of the injury from the "incidents of governmental authority," because the injury is not dignitary and because there is no outward sign of governmental authority to aggravate it.

B. The court of appeals' contrary conclusion does not withstand scrutiny. Asserting that private insurance companies "become an arm of the State" when they "act under the construct of the Workers' Compensation system," the court characterized workers' compensation as a system "of public benefits which honor State entitlements," and likened private insurers to administrators of that system. Pet. App. 14a-15a. In particular, the court of appeals reasoned that the power to terminate the payment of public benefits is a "power * * * traditionally" held by the State, and one an insurer could not exercise "without the permission and participation of the Commonwealth." *Id.* at 15a That analysis is incorrect, for several reasons.

1. State workers' compensation statutes do not create public benefits; instead, they regulate obligations arising out of private employment relationships, just as tort law did before workers' compensation statutes were enacted. Of course, Pennsylvania's workers' compensation statute, like most others, substitutes a system of no-fault liability, backed by mandatory insurance, for the previous system of tort liability in the context of work-related injuries. But nothing about that substitution converts private insurance companies into state actors. To the contrary, time and again this Court has held that "[t]he mere fact that a business is subject to state regulation"—even extensive regulation—"does not by itself convert its action into that of the State for purposes of the Fourteenth Amendment." *Blum*, 457 U.S. at 1004 (quoting *Jackson*, 419 U.S. at 350).

For example, if a State makes automobile insurance mandatory—and regulates the industry heavily, specifying the terms of coverage—insurer decisions regarding the payment of accident claims based on coverage or liability concerns remain private rather than state action. The same is true of the decisions of workers' compensation insurers. Although the purchase of insurance is mandatory, and the terms of coverage are regulated, the decision to withhold payment pending resolution of a disputed claim remains the insurer's and the insurer's alone.

In fact, the "mandatory" and "exclusive" nature of workers' compensation (Pet. App. 14a) seems particularly irrelevant, as there is no suggestion that those attributes of the system had any affect on the decisions by insurers to suspend payment for particular bills. Cf. *Jackson*, 419 U.S. at 351-352 (finding an "insufficient relationship between the challenged actions of the entities involved and their monopoly status"). Besides, obligations arising in tort are, as a general matter, mandatory rather than voluntary. Yet a private party's decision to defer payment of a potential debt

arising from tort law has never, to our knowledge, been considered "state action" under the Fourteenth Amendment.

The court of appeals' conclusion that the workers' compensation system allocates "public benefits" also flies in the face of the system's structure. See also *Crowell* v. *Benson*, 285 U.S. 22, 51 (1932). Respondents do not assert a right to *public funds* located in the state treasury. Nor will their claims be paid from the public fisc. Instead, they assert a right to *private funds* that are held by private insurers and that will remain the private insurers' unless respondents' claims are sustained. Because a private insurer's satisfaction of a claim with its own funds is not the payment of a "public benefit," its decision to defer payment pending review of a disputed claim is not properly attributed to the State. That is true even if the State pays for the underlying insurance policy, because individual payment determinations are made by, and the financial consequences of those decisions are borne by, the private insurer and not the State. See *Blum*, 457 U.S. at 1011 (rejecting contention that decisions made by physicians and nursing homes are attributable to the State, despite state "subsidization of the operating and capital costs of the facilities" and coverage for "the medical expenses of more than 90% of the patients").

2. Even if payments by private insurers could properly be characterized as public benefits, it would not follow that a private decision resulting in a deferral of payment constitutes "state action." In *Blum*, for example, this Court held that medical necessity decisions made by a physician— decisions that caused the State to adjust the patient's Medicaid benefits—were not properly attributed to the State. 457 U.S. at 1006-1007. The medical necessity determinations, the Court explained, were not made by state officials. Nor were they made based on criteria established by the State. Instead, they were "made by physicians and nursing home administrators, all of whom are concededly private parties" and who were not "influenced in any degree by the State's

obligations." *Id.* at 1005. Because such determinations regarding medical necessity "ultimately turn on medical judgments made by private parties according to professional standards that are not established by the State," *id.* at 1008, the Court held that those decisions could not be attributed to the State, *id.* at 1009; see also *id.* at 1009 n.19 ("[T]he judgment, made by concededly private parties, that [the individual] is receiving expensive care that he does not need" is "a medical one.").

The same analysis forecloses respondents' contentions here. As in *Blum*, the initial determination whether a certain treatment is reasonable and necessary—and thus should be paid immediately—is made not by state officials but by a private insurer. Here, as in *Blum*, that decision is made based not on state criteria but rather "on medical judgments * * * according to professional standards that are not established by the State," 457 U.S. at 1008. See 34 Pa. Code §§ 127.470(a), 127.467 (reasonableness and necessity determinations to be based on "generally accepted treatment protocols"). In *Blum*, those factors led the Court to determine that the privately-made medical necessity decisions were not state action. Those same factors compel a like result here.

3. Alternatively, the court of appeals relied on the "rather vague generalization," *Blum*, 457 U.S. at 1010, that the Pennsylvania statute "inextricably entangles the insurance companies in a partnership with the Commonwealth such that they become an integral part of the state in administering the statutory scheme." Pet. App. 19a. In *Burton* v. *Wilmington Parking Authority*, 365 U.S. 715, 725 (1961), this Court stated that where "[t]he State has so far insinuated itself into a position of interdependence with" a private actor, the State may be held to be "a joint participant in the challenged activity" of racial discrimination. The facts in this case do not support a like conclusion. Unlike *Burton*, this case does not involve the dignitary injury that flows from racial discrimination, which can be "uniquely aggravated" by

governmental involvement or endorsement. *Edmonson*, 500 U.S. at 622. Nor does this case involve interdependent joint activity. Pennsylvania merely oversees a workers' compensation system that allows a private insurer to postpone payment pending review of the reasonableness or necessity of the treatment involved. Because the applicable statutes and regulations leave payment-withholding decisions to the insurer's judgment, it cannot fairly be said that the State jointly participates in those decisions. See *San Francisco Arts & Athletics*, 483 U.S. at 547 n.29; *Jackson*, 419 U.S. at 357-358.

4. Finally, it makes no difference that Pennsylvania requires insurers to file requests for utilization review on "a form prescribed by the [state workers' compensation] Bureau." 34 Pa. Code § 127.452(a); see 77 Pa. Stat. § 531(5), (6) (Supp. 1998). As this Court held in *Blum*, the State is not rendered responsible for private action "by requiring completion of a form." 457 U.S. at 1006-1007, 1010. See also *Barnes* v. *Lehman*, 861 F.2d 1383, 1387 (5th Cir. 1988) ("Regulations that dictate procedures, forms, or even penalties *without dictating the challenged action* do not convert private action into state action." (emphasis added)). Under the Pennsylvania statute, the Bureau reviews the form simply "to ensure that it is properly completed," and not to "address the legitimacy or lack thereof of the request for utilization review." Pet. App. 5a; see also *id.* at 58a ("the Bureau makes no determination as to whether the medical costs are reasonable or necessary"). In short, in temporarily withholding payment, a private insurer exercises a "choice allowed by state law." *Jackson*, 419 U.S. at 357. Because the "initiative comes from it and not from the State," its action is not "'state action' for purposes of the Fourteenth Amendment." *Ibid.*

II. AN INSURER'S DECISION TO DEFER PAYMENT OF A DISPUTED CLAIM PENDING UTILIZATION REVIEW COMPORTS WITH DUE PROCESS

Even if the decisions of private insurers at issue here were determined to be state action under the Fourteenth Amendment, deferring payment of disputed claims pending further review does not violate respondents' due process rights.

A. Although the court of appeals analyzed the degree of process "due" by balancing the parties' interests under *Mathews* v. *Eldridge*, 424 U.S. 319 (1976), such a test—and the due process inquiry generally—normally applies only when a state actor seeks to "deprive" an individual of a "property interest." See U.S. Const. Amend. XIV, § 1 ("nor shall any State deprive any person of life, liberty, or property, without due process of law"); *Mathews*, 424 U.S. at 332 ("Procedural due process imposes constraints on governmental decisions which deprive individuals of 'liberty' or 'property' interests."). Although this Court has determined that the right to *continued* payment of an existing stream of benefits becomes a "property interest" once the claimant establishes entitlement, it has not held that the mere anticipation of receiving such benefits, before an application or request for them has been approved, gives the applicant a property interest in the payments requested. See *Walters* v. *National Ass'n of Radiation Survivors*, 473 U.S. 305, 320 n.8 (1985) (reserving the issue). Indeed, to say that the mere submission of a claim for payment is sufficient to give the applicant a "property" right in the requested payment itself, before the insurer, the State, or any decision-making body has passed on the propriety of payment, would in our view expand the notion of "property" beyond reasonable bounds.

That does not mean, of course, that the State could reject applications for benefits randomly or with no process at all. Even if an applicant for payment does not have a property

interest in the payment as such, the applicant does have a property interest in the *claim for payment*, *i.e.*, in the pending application that represents the possibility of, or demand for, payment. Such a claim for payment is akin to a legal claim or "chose in action," which may constitute a property interest. See, *e.g.*, *Logan* v. *Zimmerman Brush Co.*, 455 U.S. 422, 431 (1982); see *Schvartzman* v. *Apfel*, 138 F.3d 1196, 1199 (7th Cir. 1998) (discussing *Zimmerman*). A final decision rejecting a claim for payment, without further review, has the effect of terminating that claim or chose in action, and thus terminates the individual's "property right" therein. Consequently, we may assume that where a State finally rejects a claim for new benefits under a statutory scheme, it must comply with minimum procedural due process requirements. *Logan*, 455 U.S. at 431. But intermediate steps, which do no more than give rise to reasonable delays in the final adjudication of the claim for payment, do not destroy the claim (or chose in action) itself, and thus do not deprive the individual of "property" for purposes of due process. To the contrary, they merely deprive the applicant of *immediate* payment, something in which the applicant does not have a distinct property interest, and to which the Due Process Clause therefore does not, without more, apply.

Under that analysis, it is evident that the procedure to which respondents object—the temporary withholding of payment pending utilization review—does not raise due process concerns. Respondents have no property interest in immediate payment of individual medical bills, because nothing in the Act promises them a stream of payments for all medical treatments. Instead, the Act promises payment only if the treatment is reasonable or necessary, and respondents have yet to establish those pre-requisites to entitlement. Thus, unlike the recipients of fixed, monthly benefits such as social security, who obtain an unconditional right to receive payments once their entitlement status is established (subject to defeasance only if proper procedures are

employed), respondents' entitlement to payment for individual medical treatments arises only once those treatments are determined to be necessary or reasonable on a bill-by-bill basis. Since deferring payment for a reasonable interval to determine reasonableness and necessity does not deprive respondents of anything in which they have a distinct property right, doing so is consistent with the Fourteenth Amendment.

Finally, it cannot be argued that deferring payment for a reasonable time pending utilization review destroys respondents' claims for payment, in which they do have a property interest. Even after the insurer withholds payment, and if the URO upholds that decision, respondents' claims for payment remain viable, and respondents may still present them to a workers' compensation judge, who will hold a hearing and determine the matter de novo. 77 Pa. Stat. §§ 531(6)(iv), 711.1(a) (Supp. 1998); 34 Pa. Code § 127.556. Moreover, because the delays resulting from utilization review are quite modest, it cannot be argued that the delays have the effect of destroying or substantially diminishing the value of respondents' property interests in their claims for benefits. Cf. *First English Lutheran Evangelical Church* v. *County of Los Angeles*, 482 U.S. 304, 321 (1987) (normal regulatory delays do not effect a "taking" of property). Protracted delays that prevent claims from ever ripening into payment, of course, might be said to destroy the individual's interest in the claim itself, for a claim to payment is valueless if, because of such delays, payment effectively cannot be received. Here, however, the law requires utilization review to be completed within 30 days, 77 Pa. Stat. § 531(6)(ii) (Supp. 1998), and in practice review is usually completed within 70 days, see Pet. 5. Moreover, Pennsylvania law compensates for delay, offering interest at a generous rate. Pa. Stat. § 717.1(a) (Supp. 1998); 34 Pa. Code §§ 127.208(f), 127.210(d), 127.479. Because Pennsylvania's system merely defers payment for a reasonable interval pending further review, and

compensates for delay, it does not deprive respondents of any property in which they have a right.

That conclusion becomes especially apparent upon consideration of what the result would be if Pennsylvania, rather than employing its elaborately protective procedures, simply required insurers to make an initial determination regarding payment within 120 days, and permitted employees to seek review of adverse decisions before an administrative law judge after expiration of the 120-day period. In such a case, it would be apparent that the 120-day processing time, during which payment was not made, did not deprive respondents of "property" without "due process." It is therefore difficult to understand how the more protective system the Commonwealth established here—which offers the possibility of payment much earlier (within 30 or 70 days), affords prompter recourse to a workers' compensation judge, and compensates for delays—deprives respondents of "property" without "due process" in violation of the Fourteenth Amendment. Compare *Mathews*, 424 U.S. at 341-342 (delays of 10 to 11 months between request for ALJ hearing and decision).

B. Even if we assume, *arguendo*, that respondents have been deprived of a "property" interest in some measure, Pennsylvania's workers' compensation system affords respondents all the process that is due. Due process "is not a technical conception with a fixed content unrelated to time, place and circumstances," *Cafeteria Workers* v. *McElroy*, 367 U.S. 886, 895 (1961), but rather "is flexible and calls for such procedural protections as the particular situation demands," *Morrissey* v. *Brewer*, 408 U.S. 471, 481 (1972). See *Gilbert* v. *Homar*, 117 S. Ct. 1807, 1812 (1997). The "fundamental requirement" of due process "is the opportunity to be heard 'at a meaningful time and in a meaningful manner,'" *Mathews*, 424 U.S. at 333 (quoting *Armstrong* v. *Manzo*, 380 U.S. 545, 552 (1965)).

In determining whether the requirements of due process have been met, this Court has typically looked to three factors:

> First, the private interest that will be affected by the official action; second, the risk of an erroneous deprivation of such interest through the procedures used, and the probable value, if any, of additional or substitute procedural safeguards; and finally, the Government's interest, including the function involved and the fiscal and administrative burdens that the additional or substitute procedural requirement would entail.

424 U.S. at 335. Where, as here, the dispute is over the sufficiency of the procedures applicable to disputes between private parties, application of the third *Mathews* factor requires "principal attention" to the interest of the party desiring to utilize the challenged procedures, "with * * * due regard for any ancillary interest the government may have in providing the procedure or forgoing the added burden of providing greater protections." *Connecticut* v. *Doehr*, 501 U.S. 1, 11 (1991).

1. *The Employee's Interest.* The court of appeals, in our view, accorded greater weight to the employee's interest than is warranted. The insurer's temporary withholding of payment for a particular treatment does not affect the employee's disability status, or, therefore, the employee's entitlement to be reimbursed for other services that *are* found to be reasonable and necessary. *Mathews*, by contrast, involved a complete termination of disability benefits. 424 U.S. at 332, 340. Moreover here, as in *Mathews*, 424 U.S. at 340-341, eligibility for benefits is not based on need.

Although the employee's interest in payment for a particular treatment is (like the insurer's) partially financial, a deferral of payment may to some degree affect the employee's receipt of further treatment while utilization review

is pending.[6] See Pet. App. 27a-28a (deferral of payment might sometimes affect continuation of medical treatment). Pennsylvania, however, does not require providers to terminate treatment when bill payments have been deferred pending review, and some respondents acknowledge that they continued to receive treatment even though payment of their bills had been delayed. See *id.* at 27a; J.A. 29, 27, 36, 42.[7] The period of deferral is, after all, relatively brief. And it is of some significance that, if there is on occasion some delay in receiving further treatment while utilization review is under way, the result for the employee is the same as if the provider had itself chosen to consult with peers, or outside experts, before continuing treatment.

For present purposes, however, we may assume that an employee's interest in prompt payment may sometimes be substantial. That interest, however, is not so weighty as to support the finding of a due process violation, especially when the remaining two factors are considered.

2. *The Interests of Insurers and the Government.* Insurers and the Commonwealth alike have a direct and substantial interest in avoiding payment of bills for medical treatments that are not reasonable or necessary. That interest cannot be fully protected without some sort of deferral mechanism: If the bills are paid before utilization review is completed, the money is unlikely to be recovered even if the insurer later prevails on its claim. See *Mathews*, 424

[6] This assumes that an employee has an interest in the payment of his provider's bills, even if the employee has no direct liability, because future treatments may be disrupted as a result. But cf. *O'Bannon* v. *Town Court Nursing Ctr.*, 447 U.S. 773 (1980) (patients in nursing home lack due process rights with respect to decertification of nursing home, even if decertification may affect them indirectly by requiring them to move).

[7] It is possible, of course, that a provider will withhold further treatment only for those patients about whom it is most uncertain of having its bills approved, and that treatment will continue to be provided when the provider is more confident that the treatment is reasonable and necessary.

U.S. at 347. Indeed, in apparent recognition of that problem, Pennsylvania forbids the collection of excess workers' compensation payments from individual employees, and requires insurers to recover from the state Supersedeas Fund instead. See *Moats* v. *Workmen's Compensation Bd.*, 588 A.2d 116, 118 (Pa. Commw. Ct. 1991); 77 Pa. Stat. § 999. When insurers are forced to pay for unnecessary medical treatments, everyone suffers. The insurers' costs are passed along to employers in their workers' compensation premiums, and the employers in turn pass those costs on either to workers generally through decreased wages or to society through increased prices.[8]

3. *The Risk of Erroneous Deprivation.* There is no significant risk that legitimate payments will be improperly delayed or denied with much frequency under Pennsylvania's statutory scheme.

a. The Pennsylvania utilization review process is structured to obtain an objective determination on a narrowly focused issue: the reasonableness or necessity of the employee's medical treatment. 34 Pa. Code § 127.470. Because the process relies upon the written records of the employee's own healthcare provider, *id.* §§ 127.459, 127.461, and reviewers are required to discuss treatment with the provider, *id.* § 127.469, insurers are unlikely to seek utilization review (and thereby to defer payment) unless they have fair grounds for disputing the bills. Indeed, the statute imposes significant costs on an insurer that requests utilization review. The insurer not only has to bear the costs of review, 77 Pa. Stat. § 531(6)(iii) (Supp. 1998), but risks eventual re-

[8] That remains true even when the cost of unnecessary medical procedures is covered by the Supersedeas Fund. Because that fund is financed "by annual assessments on insurers and self-insurers" subject to the Act, 77 Pa. Stat. § 999(b), the costs are passed back to employers in the price of insurance, and thus eventually to employees and society at large.

payment of the bills with interest, *id.* § 717.1(a) (Supp. 1998); 34 Pa. Code § 127.210(d). And, if the matter goes before a workers' compensation judge and the employee prevails, the insurer risks having to pay the employee's litigation costs, including attorney's fees, if it cannot show that it had a reasonable basis for contesting payment. 77 Pa. Stat. § 996 (Supp. 1998).

Moreover, the utilization review process is designed to identify promptly any errors in the insurer's initial judgment. Utilization reviewers must be "impartial," 77 Pa. Stat. § 29 (Supp. 1998), and "licensed in the same profession and hav[e] the same or similar specialty as that of the provider of the treatment under review," *id.* § 531(6)(i) (Supp. 1998); 34 Pa. Code § 127.466. They must justify their decisions based on "generally accepted treatment protocols." 34 Pa. Code §§ 127.470(a), 127.467. And they must review the employee's medical records, 34 Pa. Code §§ 127.459, 127.460, and discuss the matter with the treating physician, *id.* § 127.469. Given the incentives that treatment providers have to justify their medical judgments—and thus their fees as well—it seems unlikely that sound justifications for treatment will be overlooked.

b. Despite those protections, the court of appeals concluded that due process prohibits the withholding of payments unless the employee has been permitted to participate in utilization review. Pet. App. 29a, 32a. "Without some sort of indication from the very individual who is receiving the questioned medical treatment as to its success," the court concluded, "the risk of erroneously terminating an employee's medical benefits is too high." *Id.* at 31a.

The court of appeals' rationale for that conclusion is little more than conjecture. The court suggested that the employee's input might be critical where the treatment is only marginally effective but is the sole possible treatment, or that it might prove critical where the URO does not understand how the treatment fits in with the overall

medical care related to the disability. Pet. App. 31a-32a. It is reasonable to expect, however, that concerns regarding effectiveness of a treatment and available alternatives, as well as how the treatment fits in with the overall medical care of the employee, would appear in the employee's medical records or in general treatment protocols the reviewers must consult. And even if they did not, the treating provider, with whom utilization reviewers must consult, would surely discuss those matters.

Nor is it likely that the employee's participation would appreciably reduce the risk of error. Utilization review determinations are concerned with objective medical judgments, not questions of credibility. See Pet. App. 31a; see also *Mathews*, 424 U.S. at 344; *Richardson* v. *Perales*, 402 U.S. 389, 407 (1971). The statement of an employee, who is not schooled in medicine, is unlikely to add anything significant to the input of his provider. The employee, in any event, is given a full opportunity to be heard when the matter comes before a workers' compensation judge, after the expedited utilization review procedures are completed. See 77 Pa. Stat. §§ 801-836.

Finally, while permitting an employee to submit a personal statement would not necessarily be "unduly onerous or administratively burdensome to implement," it would frustrate prompt utilization review. See 77 Pa. Stat. § 531(6) (ii) (Supp. 1998) (time limit of 30 days for decision). If the employee were permitted to submit a statement or other additional evidence to the URO, fairness might suggest that the insurer should be permitted to do so as well. The purpose of utilization review, however, is to provide an initial and streamlined check on insurer withholding decisions, using objective and available medical evidence, not to conduct a mini-trial. To the extent adversarial presentations by the interested parties (the employee and the insurer) may eventually be required, Pennsylvania has reasonably determined that they should be reserved for a hearing before the

workers' compensation judge, after the initial utilization review procedures have been completed. The court of appeals' requirement that insurers pay for medical treatment until utilization review is completed and the employee's perspective is heard would undercut the very reason for permitting insurers to withhold payment pending review—to enable them to avoid paying for medical treatments that in fact are neither medically necessary nor reasonable.

c. If there is any remaining doubt regarding the requirements of due process in this setting, "substantial weight" should be given to Pennsylvania's determination "that the procedures [it has] provided assure fair consideration of the entitlement claims of individuals." *Mathews*, 424 U.S. at 349. That is especially so considering the widespread use of utilization review procedures and the nearly uniform state practice of permitting insurers to withhold payment pending review. See Pet. 24 (39 of 41 surveyed jurisdictions permit pre-review deferral of payment); compare *Doehr*, 501 U.S. at 17-18. While the concerns identified by the court of appeals are appropriate for the Pennsylvania Legislature to consider, they are an insufficient basis on which to overturn that body's judgment regarding the most appropriate procedures to employ.

CONCLUSION

The judgment of the court of appeals should be reversed.

Respectfully submitted.

SETH P. WAXMAN
Solicitor General
FRANK W. HUNGER
Assistant Attorney General
EDWIN S. KNEEDLER
Deputy Solicitor General
JEFFREY A. LAMKEN
Assistant to the Solicitor General
BARBARA C. BIDDLE
JACOB M. LEWIS
Attorneys

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No. 97-2000

IN THE

Supreme Court of the United States

OCTOBER TERM, 1998

AMERICAN MANUFACTURERS MUTUAL INSURANCE COMPANY, *et al.*,

Petitioners,

vs.

DELORES SCOTT SULLIVAN, *et al.*,

Respondents.

ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

REPLY BRIEF FOR RESPONDENT SCHOOL DISTRICT OF PHILADELPHIA IN SUPPORT OF PETITIONERS

JAN M. RITCHIE
Counsel of Record
PATRICIA FARRELL KERELO
MARK PFEIFFER
SCHUBERT, BELLWOAR,
CAHILL & QUINN
Attorneys for Respondent
School District of Philadelphia
1500 John F. Kennedy Boulevard
Suite 1400
Philadelphia, Pennsylvania 19102
(215) 587-0146

150451

Counsel Press LLC
FORMERLY LUTZ APPELLATE SERVICES
(800) 274-3321 • (800) 359-6859

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The brief filed by Respondents in Opposition to Petitioners (hereinafter referred to as "Plaintiffs") demonstrates that all parties agree on one point — it is imperative that this Court address whether Pennsylvania's utilization review process comports with the due process requirements of the Fourteenth Amendment. Notwithstanding Plaintiffs' posture that due process issues are not before this Court, Plaintiff's brief at 2-4, 19; Plaintiffs concede that if this Court declines the opportunity to reach the second issue presented in Petitioners' Petition for Writ of Certiorari, the affect would "wreak havoc" on Pennsylvania's workers' compensation system. *Id.* at 2 n.4; *see also id.* at 17.

Plaintiffs' brief is misleading with respect to the status of the Commonwealth Defendants in this matter and the justiciability of the present case or controversy. There has been no "settlement" in this case between the Plaintiffs and the Commonwealth Defendants. Plaintiffs' allusions to the contrary are simply false. *See id.* at 2-3, 14-15 n.18.

1. Due Process Issues Are Squarely Before This Court For Review.

Plaintiffs' argument that no due process issues are before the Court is simply misplaced. This court granted, in whole, Petitioners' Petition of Writ of Certiorari and the second issue framed therein is:

> Whether the due process clause requires workers' compensation insurers to pay disputed medical bills prior to determination that the medical treatment was reasonable and necessary.

As this court is aware, the School District also filed a timely Petition for Certiorari in support of Petitioners' challenge to the Third Circuit's erroneous decision on due process grounds and presented a separate issue challenging the classification of the interest sought to be protected as not falling within the definition of "property interest" to which due process protection extends. Similarly, the Commonwealth filed a Conditional Cross-Petition for Certiorari in support of the petitions filed by Petitioners and the School District challenging the Third Circuit's decision on the state actor ruling as well as the due process holdings. Thus all defendants have challenged or otherwise sought to have reversed the Third Circuit's

misapplication of the Fourteenth Amendments due process requirements to Pennsylvania's utilization review system. The due process issue is compelling and squarely before this Court for review.

Plaintiffs assert that Petitioners have conceded that the Third Circuit properly ruled that the utilization review process was unconstitutional due to a lack of notice and opportunity to be heard, citing Petitioners' brief at p. 30. However, Petitioners never conceded that the procedures were unconstitutional due to lack of an opportunity to be heard as Plaintiffs contend. *Id.* at 4 n.7. Rather, Petitioners have consistently maintained that the procedures were constitutionally sound.

Moveover, the School District has consistently maintained that the procedures satisfy the mandates of due process because claimants are provided sufficient meaningful notice and a meaningful opportunity to be heard. Plaintiffs never addressed this argument in their brief. *Cf. id.* at 13 n.16.

As discussed more fully in the School District's brief, only a certain course of treatment is reviewed at any one time, the claimants are not deprived of their entitlement to ongoing reasonable and necessary medical benefits and the notice provided is sufficient to keep claimants advised of the pendency of the review and of an opportunity to be heard when practical. *Mullane v. Central Hanover Bank and Trust Co.*, 339 U.S. 306 (1950) (notice need only apprise interested parties of the pendency of an action and afford them an opportunity to participate at a meaningful time). Since a process that would provide claimants with an opportunity to be heard before bills are submitted for review is impracticable, considering the requirement of the Pennsylvania Workers' Compensation Act that medical bills must be paid within thirty days, the utilization review process is constitutionally sound and does not violate the Fourteenth Amendment.[1]

1. Although Plaintiffs assert that no party disputes that the challenge statute permitted a recognized property right to be disrupted without pre-deprivation notice, the School District has maintained that claimants are not deprived of a property right without due process during the utilization review process. Claimants have simply chosen not to address the School District's arguments or analysis in their brief, presumably because they have no response to offer.

2. The Commonwealth Defendants Remain Parties In This Matter And The Issues Presented Herein Are Not Moot.

Even if a "settlement" was achieved with only the Commonwealth Defendants, neither the settlement with those defendants nor the choice of those defendants to change the conduct of which the plaintiff complains renders moot the present case or controversy between the Plaintiffs and Petitioners or the School District as Plaintiffs argue. *Id.* at 3 n.6. *See* L. Tribe, *American Constitutional Law* 89 (1988) (where a plaintiff seeks damages, a defendant's voluntary cessation of the conduct about which the plaintiff complains is irrelevant to the issue of mootness).

Petitioners and the School District presently face the possibility of enormous damages and, if the Third Circuit's decision is not reversed, will be left with a workers' compensation system that continues to encourage the exodus of business from Pennsylvania. This is certainly not a result that the legislature intended.[2]

The Commonwealth has not "altered" its procedures for utilization review to render the system constitutionally sound and the Third Circuit's *Sullivan* decision has not resolved the due process issues. *Id.* at 3. Although the Commonwealth changed its initial notification of utilization review form to try to mitigate the effect of the Third Circuit's *Sullivan* decision on Pennsylvania's system while this challenge is pending before this Court, the Commonwealth has not changed its utilization review procedures to provide employers relief from paying exorbitant unreasonable and unnecessary medical expenses with no opportunity to recoup these losses.

2. In their brief, Plaintiffs do not attempt to counter the legislative history of Act 44 or specifically address the intent of Pennsylvania's legislature in enacting Act 44. As methodically recounted in the brief of Petitioner and the School District, Act 44 was enacted for the express purpose of curtailing the exodus of jobs from the state as a direct result of the high cost of workers' compensation and the abuse of the system by medical providers. Rather, Plaintiffs summarily discount the legislative intent in enacting Act 44 as "political pressure" without identifying the reason or source of the pressure. *Id.* at 10.

CONCLUSION

For the foregoing reasons and those stated in the Brief of Respondent School District of Philadelphia in Support of Petitioners, the judgment of the United States Court of Appeals for the Third Circuit should be reversed and the judgments of United States District Court Judge Buckwalter reinstated.

Respectfully submitted,

JAN M. RITCHIE
Counsel of Record
PATRICIA FARRELL KERELO
MARK PFEIFFER
SCHUBERT, BELLWOAR,
CAHILL & QUINN
Attorneys for Respondent
School District of Philadelphia
1500 John F. Kennedy Boulevard
Suite 1400
Philadelphia, Pennsylvania 19102
(215) 587-0146

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AMERICAN MANUFACTURERS MUTUAL INSURANCE COMPANY, ET AL., PETITIONERS

v.

DELORES SCOTT SULLIVAN, ET AL., RESPONDENTS

On Writ of Certiorari to the United States Court of Appeals for the Third Circuit

REPLY BRIEF FOR PETITIONERS

ROBERT MCL. BOOTE
BURT M. RUBLIN
Ballard Spahr Andrews & Ingersoll, LLP
1735 Market Street
Philadelphia, PA 19103
(215) 665-8500

Counsel for All Petitioners Except Donegal Mut. Ins. Co.

ROBERT E. KELLY, JR.
Duane, Morris, Heckscher LLP
305 N. Front Street
Harrisburg, PA 17108
(717) 237-5500

Counsel for Donegal Mut. Ins. Co.

MICHAEL W. MCCONNELL
Counsel of Record
ALAN E. UNTEREINER
ROY T. ENGLERT, JR.
STEFFEN N. JOHNSON
SHARON SWINGLE
Mayer, Brown & Platt
190 South La Salle Street
Chicago, IL 60603
(312) 782-0600

Counsel for All Petitioners

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RULE 29.6 STATEMENT

Pursuant to Rule 29.6, all parent companies and nonwholly owned subsidiaries of each of the corporate petitioners are listed in the Petition for a Writ of Certiorari at ii-iii and the Brief for Petitioners at ii.

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REPLY BRIEF FOR PETITIONERS

In our opening brief, we showed that petitioners' decisions to invoke utilization review and defer payment of contested bills for workers' compensation medical care, although authorized by Pennsylvania law, are not "fairly attributable to the State." Neither the payment of medical bills for injured workers nor the decision to dispute a given therapy has ever been the State's function or duty. Postponing payment of disputed claims, moreover, is commonplace in private business, and the State here neither compels nor encourages such delays. In short, the Fourteenth Amendment's limitations, which govern deprivations of property *by the state*, do not apply in this case.

Respondents' first answer is to suggest that, because this case is a "facial" or "direct" challenge, the Court may dispense with its traditional analysis and find state action solely on account of the existence of a body of workers' compensation law, without regard to either petitioners' identity as private entities or the particular actions being taken in response to that law. Alternatively, they offer an "all things considered" theory of state action, under which the principles established by this Court's decisions are merely "factors" or "guides," to be applied "flexibly" in light of the "factual subtleties" of each "unique" case. Accordingly, respondents cite a laundry list of factors said to add up to significant state involvement in the Pennsylvania workers' compensation scheme.

Neither of these theories is supported by precedent. The notion that a "facial" challenge must succeed because the State enacted and administers the governing regulatory scheme flies in the face of this Court's repeated holdings that state action requires *both* state authorization *and* significant state involvement in the particular action being challenged. As for the claim that the State's involvement in regulating workers' compensation insurance somehow makes the State responsible for insurers' decisions to delay payment for disputed treatment pending utilization review, such an approach would turn virtually every decision of a regulated entity into state action.

Respondents' due process arguments are equally unavailing. They lead with a frivolous argument that the due process issue on

which this Court granted certiorari — the constitutionality of Pennsylvania's payment suspension provision — is moot because petitioners chose not to seek review of, and the Commonwealth has modified its procedures to comply with, other portions of the due process holding below. On the merits, respondents offer no real answer to a number of our contentions: that individuals are entitled to due process hearings only with respect to their own eligibility for benefits and not with respect to payments to third-party providers; that traditional practice under state and federal law confirms the basic fairness of Pennsylvania's procedures; and that submission of a bill is akin to an application for benefits and employees have no vested interest in payment for unreasonable or unnecessary care. The only point they seriously put forward — that permitting insurers to delay payment during utilization review does not survive the *Mathews* balancing test — does not withstand scrutiny.

I. State Action

A. A "Direct Challenge" To The Constitutionality Of Pennsylvania's Workers' Compensation Law Is Subject To Traditional State Action Analysis

In the opening pages of their argument, respondents advance the remarkable claim that traditional state action analysis does not apply here because this case involves a "facial" or "direct challenge to the constitutionality of a state statute." Resp. Br. 18. In such cases, respondents argue, the Court "by necessity" must "focus on the state statute and its underlying policy," without regard to either "the identity of the defendant" or the particular "act or decision by a private actor or entity who is relying on the challenged law." *Id.* at 16. Indeed, respondents suggest that there is no "need to address the state action question, as the facial attack apparently render[s] that unnecessary." *Id.* at 17 n.20.

Respondents' theory lacks any support in this Court's precedents. No decision of this Court has ever held that a facial challenge obviates the need to address state action. Indeed, the

terms "facial," "direct," and "indirect" appear nowhere in those decisions — not even in the cases cited by respondents.[1]

Moreover, respondents' approach is foreclosed by this Court's repeated instruction that state action requires *both* that a "deprivation must be caused by the exercise of some right or privilege created by the State or by a rule of conduct imposed by the State" *and* that "the party charged with the deprivation * * * be a person who may fairly be said to be a state actor." *Lugar* v. *Edmondson Oil Co.*, 457 U.S. 922, 937 (1982); accord *Flagg Bros., Inc.* v. *Brooks*, 436 U.S. 149, 156 (1978) (one "must establish not only that [the putative state actor] acted under color of the challenged statute, but also that its actions are properly attributable to the State"). Respondents' theory would contravene these precedents by rendering the second part of this inquiry — whether action taken in response to the governing rule is fairly attributable to the State — irrelevant.

Under respondents' theory, a plaintiff challenging the private conduct of another party need only characterize the claim as a "facial challenge" to the statute under which that party acts, and state action limitations disappear. Thus, if the plaintiff in *Jackson* v. *Metropolitan Edison Co.*, 419 U.S. 345 (1974), had only thought to bring a "direct" or "facial" challenge to the statute permitting the private utility to terminate electrical service without giving the customer notice and the opportunity to be heard, the case would have come out the other way. If the plaintiffs in *Blum* v. *Yaretsky*, 457 U.S. 991 (1982), had simply characterized their action as a "facial" challenge to the statute permitting transfer to a different nursing home, they would have prevailed. State action jurisprudence simply does not turn on such semantics.

Respondents' fallacy is in thinking that the constitutionality of a statute can be evaluated independently of the status of the party acting pursuant to the statute. But the Due Process Clause only

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[1] It is not obvious that the plaintiffs' complaint was facial in nature. The Amended Complaint contains more than 150 allegations pertaining to the application of the statute to named individuals. See ¶¶ 92-264, J.A. 24-42.

applies when life, liberty, or property is taken away *by the state*.[2] Of course, "the enactment and enforcement of an unconstitutional state law" — by the state — "is state action" (Resp. Br. 25), but it is not state action for a private party to take advantage of rights granted by a statute, unless that party can "fairly be said to be a state actor." *Lugar*, 457 U.S. at 937.

A simple example involving unquestionably private conduct may help to expose the fallacy. Surely no one doubts that a private employer's dismissal of an at-will employee is private action, and that the Due Process Clause does not of its own force require the employer to give the employee advance notice or the opportunity to be heard. Suppose, however, that a State decided to enact worker-protection legislation limiting the employer's power to dismiss its employees. Suppose the statute required that the employer file a form with the State before dismissing the employee and submit the matter to an independent "dismissal justification review organization." That organization would determine whether the dismissal was justified and, in the event that it was not, reinstate the employee with back pay. Now an employee brings a constitutional challenge, claiming that it violates due process to allow the employer to dismiss him without advance notice and an opportunity to be heard. He claims that the employer is constitutionally obligated to keep him on the payroll until *after* the dismissal justification review has been completed.

In that example, as here, it should make no difference whether the case is characterized as a facial challenge or as an as-applied challenge. A private employer dismissing an employee is not a state actor no matter how the constitutional challenge is framed. The statute — which expands the employee's rights compared to those he would have if the State had not acted — cannot, therefore,

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[2] Respondents' observation (at 17) that, in cases where this Court has "found that the law violates the procedural due process or the equal protection clause, it has invariably found that the private actor or entity invoking or relying on the unconstitutional law is a state actor" confuses cause with effect. The Court could not hold that due process or equal protection had been violated unless the party whose behavior is being challenged is a state actor.

be held to violate the Due Process Clause. As the Court explained in *Flagg Bros.*, "[i]t would intolerably broaden * * * the notion of state action under the Fourteenth Amendment to hold that the mere existence of a body of property law in a State, whether decisional or statutory, itself amounted to state action." 436 U.S. at 160 n.10.

B. The Miscellaneous Factors Identified By Respondents Do Not, Individually Or Collectively, Demonstrate State Action In This Case

Perhaps aware that this Court's decisions will not sustain the claim that styling their lawsuit as a "direct" challenge allows them to avoid the strictures of traditional state action analysis, respondents resort to a "totality of the circumstances" or "all things considered" theory of state action. Resp. Br. 32.[3] But, as we show below, the various elements identified by respondents — the filing of a form, the State's alleged "supervision" of private UROs, the claim that payment for medical care is a "public benefit" or "vested state entitlement," the State's and insurers' mutual interest in cost containment, the "exclusivity" of the system, and the involvement of state personnel who administer the system — do not, individually or collectively, warrant the conclusion that the decision to invoke utilization review and withhold payment is state action. We consider their arguments in turn.

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[3] Respondents claim that the analysis in our opening brief is inconsistent with *Edmonson* v. *Leesville Concrete Co.*, 500 U.S. 614 (1991). Resp. Br. 31-33. In our opinion, the three factors discussed in *Edmonson* are roughly equivalent to the tests for state action employed in this Court's other cases, expressed in slightly different language. Thus, on the "Government's Assistance and Benefits," see Pet Br. 22-25; on "Traditional Government Function," see Pet. Br. 17-20; and on "Aggravation by Unique Incidents of Governmental Authority," see Pet. Br. 22-25. We do not believe that *Edmonson* should be read as impliedly overruling *Jackson*, *Blum*, *Rendell-Baker* v. *Kohn*, 457 U.S. 850 (1982), or the other decisions on which we rely, which are far closer to this case in their factual circumstances than *Edmonson*.

1. Respondents' Claim That The Decision To Invoke Utilization Review Receives Overt State Assistance And Encouragement

Respondents' central theme is that the State's mechanisms to *impede* insurers' behavior — its involvement in rejecting "requests" for utilization review, and in penalizing insurers who postpone payment without filing such requests — amount to "the overt *assistance* of the state" and compel a finding of state action. Resp. Br. 26 (emphasis added). "Like the non-claim statute involved in *Tulsa* [*Professional Collection Services, Inc.* v. *Pope*, 485 U.S. 478 (1988)]," they argue, an insurer's decision to withhold payment "is not self-executing." *Ibid.*

This argument confuses regulation with assistance. Undoubtedly, the insurers' right to defer payment of a disputed claim (see Pet. Br. 25 n.14) has been curtailed by state law. The insurer is required to file a form with the State,[4] to submit to a state-approved utilization review procedure,[5] to pay the costs of that procedure, and to pay 10% annual interest on any bill for disputed

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[4] This Court has made clear that a private party does not become a state actor on account of being required to file a form with a state agency. See *Blum*, 457 U.S. at 1006-07 (where "[private actors], and not the forms, make the decision about whether the patient's care is medically necessary," one "cannot say that the State, by requiring completion of a form, is responsible for the [private actor's] decision"); *Jackson*, 419 U.S. at 354 (rejecting a claim that the State "specifically authorized and approved" a practice merely because it appeared in a tariff "filed with the Public Utility Commission" for its approval or disapproval). In this case, the requirement of filing a form is especially inconsequential, since the form is reviewed only for completeness; the State makes no judgment about the substance of the insurer's request for utilization review. See Pet. Br. 22-23.

[5] Respondents emphasize the State's role in supervising and setting standards for UROs. See Resp. Br. 28. That might be relevant if the issue were whether URO decisions are "state action," but it is irrelevant to whether the insurer's decision to seek utilization review and postpone payment of disputed bills is state action. Even if utilization review were performed by a state agency, the insurer's decision would remain private.

medical care that is ultimately determined to be reasonable and necessary. But this cannot be described as "assistance"; it is state regulation of what would otherwise be a self-executing business decision.

Respondents' similar argument (at 38-40) that insurer payment decisions are state action because they are "aggravate[d] by unique incidents of governmental authority" fails for the same reason. The "unique incident" of governmental authority cited by respondents is the existence of Pennsylvania's regulatory scheme governing disputes over the reasonableness and necessity of treatment. The regulatory scheme does not put the State's imprimatur on insurers' decisions; rather, it constrains insurers' previously unfettered business judgment.

Tulsa Professional, on which respondents principally rely (see Resp. Br. 26), is in marked contrast. That case involved a due process challenge, based on inadequate notice, to an Oklahoma nonclaim statute that barred creditors from bringing claims against an estate if not presented to the executrix within two months of the published commencement of probate proceedings. Without the *assistance* of both the state statute and the probate court, the executrix would have been powerless to bar creditors' claims. "The probate court is intimately involved throughout, *and without that involvement the time bar is never activated.*" 485 U.S. at 487 (emphasis added). Here, by contrast, had the State not gotten "involved," petitioners would have had more freedom — not less — to withhold payment of disputed sums.

For similar reasons, respondents' reliance on cases such as *Nixon* v. *Condon*, 286 U.S. 73 (1932), *Smith* v. *Allwright*, 321 U.S. 649 (1944), *Evans* v. *Newton*, 382 U.S. 296 (1966), and *Edmonson* v. *Leesville Concrete*, 500 U.S. 614 (1991), is misplaced. Each of those cases involved conduct — control over elections (*Nixon* and *Smith*), management of municipal parks (*Evans*), and selection of juries (*Edmonson*) — in which private parties had no authority to engage without delegation of authority from the State. As the Court explained in *Nixon*, those running the election possessed the power to exclude black voters from a primary election "not by virtue of any authority delegated by the party, but by

virtue of an authority originating or supposed to originate in the mandate of law." 286 U.S. at 84.

2. Respondents' Claim That Workers' Compensation Is A "Public Benefit" And "Constitutional Right"

Respondents also argue that the nature of workers' compensation makes the decisions of employers and insurers attributable to the State. The argument proceeds in two steps. First, they say that workers' compensation medical benefits are a "public benefit" or "state entitlement" to which all workers have a "constitutional right." See Resp. Br. 2, 5, 17, 23-24, 26, 27. Insurers who provide it, therefore, "are not operating in a private business sphere, but are delivering public benefits which are constitutionally protected from arbitrary deprivations." *Id.* at 27. Second, they say that the State may not, by delegating to insurers its responsibility to provide such benefits, avoid the requirements of the Constitution and attempt "to do indirectly what the state cannot do directly." *Id.* at 29. The second of these arguments rests on the first, and the first topples upon any serious scrutiny.

Workers' compensation medical benefits are neither "public" nor "constitutional" within the ordinary meaning of those terms. They are not funded or provided by the State, and the legislature could repeal them tomorrow, relegating workers to their remedies in tort. Indeed, respondents' argument would come as some surprise to Pennsylvania employers, who for years have shouldered the entire financial burden of providing workers' compensation and are under the impression that doing so is their duty under state law. The State has long *mandated* the private provision of such benefits, but it has never *assumed that responsibility*. See Pet. Br. 18-19. Respondents' "delegation" claim — that entrusting to insurers the provision of workers' compensation medical benefits, and the "right" to withhold payment for such benefits, is an attempt to evade the Constitution's requirements — thus rests on a false premise. Workers' compensation medical benefits are not a public benefit, and the Constitution does not require their provision. Thus, it makes no sense to say that the Commonwealth has "evaded" its duties by delegating "its" responsibilities to private parties.

Even if Pennsylvania *had* assumed the responsibility of funding workers' compensation benefits, that would not, without more, render insurers' independent decisions to invoke utilization review and withhold payment state action. Medicaid is a state-funded program, but this Court has held that private decisions, made during utilization review, to transfer Medicaid patients to lower levels of care do not implicate constitutional protections. *Blum*, 457 U.S. at 1012.

3. Respondents' Claim That Petitioners Are Performing An "Exclusive Public Function"

The foregoing points also illustrate the fallacy of respondents' claim that petitioners are performing a "traditional" or "exclusive" public function. Resp. Br. 37. For example, respondents contend that, because "the state guarantees the delivery of medical care to the injured worker by imposing upon the employer the obligation to pay for it," the "provision of workers' compensation benefits in Pennsylvania is * * * an exclusive state function." *Id.* at 36. But respondents' admission that it is *employers* who have always been obligated to provide workers' compensation itself demonstrates that providing such benefits is not a "public function" — let alone a "traditional" or "exclusive" one.[6] As the Court explained in *Jackson*, "public function" analysis does not apply where the law "imposes an obligation to furnish service on [a private entity]," but "imposes no such obligation on the State." 419 U.S. at 352-53.

Respondents likewise maintain that the public function test is satisfied because "the state has had exclusive control over the stoppage of an injured worker's medical benefits since 1984" and

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[6] Respondents suggest that "[a]fter *Edmonson* [v. *Leesville Concrete*] much debate ensued as to whether or not the public function test still required exclusivity." Resp. Br. 44. We believe that the weight of this Court's authority holds that exclusivity is a central part of the public function test. See *Blum*, 457 U.S. at 1005; *Jackson*, 419 U.S. at 357; *Flagg Bros.*, 436 U.S. at 158-61. We hasten to add, however, that the Court need not resolve the debate in this case: neither providing workers' compensation insurance nor withholding payment of disputed claims is typically a public function at all, much less an *exclusive* public function.

insurers were thus not permitted to delay payment of bills for disputed treatment without the approval of a workers' compensation judge until Act 44 was enacted in 1993. Resp. Br. 36, 45. Yet for most of the life of the workers' compensation system,[7] power to defer payment of disputed bills rested with insurers. The fact that the State assumed control for a brief period does not mean that for constitutional purposes this has become an inherently or exclusively state function. Withholding payment for disputed claims is a routine aspect of private contractual relations in the insurance business.[8]

4. Respondents' Claim That The Pennsylvania Act Satisfies The "Joint Participation" Test

Throughout their brief, respondents sound the refrain that invoking utilization review is akin to "promoting the state's policy of cost containment." Resp. Br. 17; accord *id.* at 18, 31. They further develop this argument in the "joint participation" section of their brief (at 40-44). They contend that, because "[t]he state's policy of cost containment was intended to further its own interest in attracting business to Pennsylvania," the legislature "ensured that employers and their insurers would derive economic benefit directly from the utilization review provisions, who stand to save money each time they invoke the process." *Id.* at 42. "The employer's decision to invoke review in any particular case, therefore, is inev-

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[7] In fact, contrary to respondents' contention, the change came about in 1978, when the Pennsylvania legislature amended the statute to require payment for disputed care pending administrative review. See *Fuhrman* v. *Workers' Comp. App. Bd.*, 515 A.2d 331, 333-35 (Pa. Commw. Ct. 1986), appeal dismissed, 540 A.2d 267 (Pa. 1988). The relevant event in 1984 was the district court decision in *Baksalary* v. *Smith*, 579 F. Supp. 218 (E.D. Pa. 1984), appeal dismissed, 469 U.S. 1146 (1985), which pertained to indemnity rather than medical benefits.

[8] Respondents make much of the fact that workers cannot "opt out" of the Pennsylvania system. See Resp. Br. 6 n.9, 7, 24 n.25. That, however, does not render any of the participants in the system state actors. Some states have made no-fault insurance the exclusive remedy for automobile injuries and do not permit accident victims to opt out. That does not make no-fault insurers or their policyholders state actors.

itably intertwined with the state's interest, even though the state is not consulted in advance." *Id.* at 42, 43.

This argument has no logical stopping point: the State benefits in some abstract way *anytime* a private party acts in a manner consistent with the law. Does complying with traffic laws make an automobile driver a "promoter of the State's policy of safe driving"? Does complying with minimum wage laws make a private employer the State's "promoter of a fairly compensated workforce"? If a company chooses to invest in one line of business rather than another because the State has provided tax incentives, does that fact make the company's decision — and not just the State's enactment of the statute — state action?

In *Blum*, this Court rejected the claim that the State's extensive funding and power to license rendered it a "joint participant" in private nursing homes' discharge and transfer of Medicaid patients. 457 U.S. at 1010-11. *Blum* thus confirms that this Court's "joint action" cases require far greater mutual benefit than is present here.

Respondents attempt to distinguish *Blum*, stating (at 43):

> Although the utilization review [in *Blum*] was undertaken in accordance with state regulations, and the state was ultimately notified by the nursing home and adjusted the payment to the nursing home accordingly, there was absolutely no interaction with the state until the decision to perform utilization review had been made, the review completed, and the ultimate decision as to the appropriate level of care determined. The procedures were entirely self-executing.

This is a very selective reading of the facts in *Blum*. Virtually every factor identified by respondents to support their claim of state action was present in greater force in *Blum*. For example, respondents make much of the fact (at 26) that state personnel are involved in the review and processing of forms notifying the State that an insurer is invoking utilization review, yet this fact was also present in *Blum*. 457 U.S. at 1006-07, 1010. Likewise, they make a great deal of the fact that state personnel "supervise" or "monitor" UROs (at 28), but that too was true in *Blum*. 457 U.S. at 1008, 1009 n.21. Respondents say (at 42) that the State stands to gain from the invocation of cost containment procedures such as

utilization review, but in *Blum* the State benefited far more directly, in the form of decreased Medicaid expenditures. 457 U.S. at 994, 1011. The decision to invoke utilization review here is left entirely to the business judgment of insurers, whereas in *Blum* both the State and the private facility were required — at risk of losing federal funding — to safeguard against all unnecessary care. *Id.* at 994 n.3, 1007-08. It is said here (Resp. Br. 5) that workers' compensation medical benefits are a "public benefit," but in *Blum* it was undisputed that the Medicaid benefits at issue were public in nature. 457 U.S. at 993-94. In short, if *Blum* did not involve state action, it is inconceivable that petitioners' actions in this case are subject to constitutional review.

II. Due Process

A. This Court Should Resolve The Due Process Question

As a preliminary matter, we stress the importance of resolving the due process question even if the state action issue is decided in petitioners' favor. On this point (putting aside a frivolous mootness issue, discussed below), all parties agree. If this Court reversed on the state action issue but left the due process holding intact, it would — in respondents' words (at 2 n.4) — "wreak havoc in Pennsylvania's workers' compensation system." Workers' compensation involves private and governmental employers in an integrated system, with sharing of the risks of paying for unreasonable or unnecessary medical care. It would not be practicable to have different rules apply to each. This Court granted certiorari on both questions presented, and decision in petitioners' favor on the first would *not* make resolution of the second unimportant.

B. The Due Process Question Is Not Moot

Respondents argue (at 3 & n.6) that the due process question on which this Court granted certiorari is moot.[9] They note that in response to the Third Circuit's decision the Commonwealth has "changed its procedures to ensure that injured workers subject to utilization review are provided with a notice which informs them

[9] Respondents made their mootness argument in their Brief in Opposition (at 19), and the Court nevertheless granted certiorari without limiting the questions presented.

of their opportunity to submit a written statement to the utilization reviewer and that if the review is adverse, their medical benefits may be lost." *Id.* at 3. They further contend that the "Commonwealth is not defending the pre-*Sullivan* statute" and is no longer a participant in these proceedings. *Id.* at 3 & n.6. Neither of these arguments establishes mootness, although the latter does misstate the record.

We concede that controversy over the requirements of notice and an opportunity for the employee to submit a written statement to the utilization reviewer would be "moot" — because we chose not to seek further review of those aspects of the decision below. Pet. Br. 9.[10] But that does not detract from the justiciability of the question presented: whether insurers or employers may delay payment of disputed bills pending utilization review. The relevant provision of 77 Pa. Stat. Ann. § 531(5) has not been repealed,[11] and neither the petitioners nor the Commonwealth has conceded the statute's unconstitutionality. Petitioners have steadfastly challenged this part of the Third Circuit's holding throughout the litigation, and made it one of our two questions presented. The Commonwealth also petitioned this Court for review on the due process issue. *Butler* v. *Sullivan*, No. 98-161 (July 10, 1998). Despite denial of its cross-petition, the Commonwealth remains a party in this case. SUP. CT. R. 12.6. And although the Commonwealth has waived briefing and argument, it has noted that its "interests are generally aligned with those of the petitioners." Letter from John G. Knorr, III, Pennsylvania Chief Deputy Attorney General, to Sandy Nelsen, Merits Clerk, at 2 (Nov. 25, 1998). Any suggestion

[10] Although we did not seek review of these issues, we do not agree with or concede the correctness of the Third Circuit's analysis of them.

[11] Respondents appear to believe that, because the Third Circuit struck down a provision of Section 531(5) as unconstitutional, this Court cannot review its constitutionality unless the Pennsylvania legislature reenacts it. Resp. Br. 3-4 & n.6. Respondents cite no authority for this proposition, which defies both logic and precedent. See, *e.g.*, *Timmons* v. *Twin Cities Area New Party*, 520 U.S. 351 (1997); *Lambert* v. *Wicklund*, 520 U.S. 292 (1997).

that petitioners or the Commonwealth has conceded the due process issue before this Court is absurd.

Even if the Commonwealth had withdrawn its opposition to the Third Circuit's due process holding, its actions would not bar review. The decision of the Third Circuit precludes petitioners from taking advantage of the statute permitting delays in payment for disputed medical care pending utilization review. Petitioners have discontinued this practice only because their motion to stay issuance of the Third Circuit's mandate was denied. See *Sullivan* v. *Barnett*, No. 96-2140 (3d Cir. Apr. 21, 1998). Moreover, the School District of Philadelphia, which is likewise a party to this case and has filed a brief in support of petitioners, also presses the due process argument. Should the Third Circuit's due process holding be overturned, petitioners (and presumably the School District and other employers, both private and governmental) intend to resume delaying payment of bills for disputed care pending utilization review. The case is therefore not moot. *Firefighters Local Union No. 1784* v. *Stotts*, 467 U.S. 561, 569 (1984); *Coopers & Lybrand* v. *Livesay*, 437 U.S. 463, 465 n.3 (1978).[12]

C. Petitioners Are Not Required To Bring An "All-Or-Nothing" Challenge To The Due Process Holding

In a related argument, respondents assert that this Court may not review the due process question because the petitioners have not challenged the portions of the Third Circuit's holding requiring them to give workers greater notice of the potential consequences of utilization review and an opportunity to submit a written statement to the utilization reviewer. See Resp. Br. 3, 4 n.7, 21. As a result, respondents assert, "the Third Circuit's decision that the statute was unconstitutional must stand regardless of how this Court might view the other due process concerns raised by Petitioners." *Id.* at 21. This contention flies in the face of standard appellate practice, under which an appellant or petitioner is permitted to frame a question presented "as broadly or as narrowly as he sees fit." *Yee* v. *City of Escondido*, 503 U.S. 519, 535 (1992).

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[12] Of course, if this case had become moot, the proper disposition would be to vacate the judgment below and remand for dismissal of the case. *United States* v. *Munsingwear, Inc.*, 340 U.S. 36, 39 (1950).

In *Califano* v. *Yamasaki*, 442 U.S. 682 (1979), for example, the government petitioned for certiorari of the lower court's "holding that the Due Process Clause required a prerecoupment oral hearing" in a case involving overpayments under the Social Security Act, but it "did not request review of the holding that notice of recoupment was constitutionally defective." *Id.* at 692. Certiorari was granted, and the Court limited its review to the need for oral hearing. *Id.* at 695-97. Similarly, in *Baxter* v. *Palmigiano*, 425 U.S. 308, 324 n.6 (1976), the Court declined to address the holdings below with respect to notice and the requirement of a neutral hearing body where the petitioners chose not to challenge them on certiorari. There was no suggestion in either case that a concession of inadequate notice required affirmance of the lower court's holding *in toto* or dismissal of the writ.

There is nothing "advisory" (Resp. Br. 3) about the ruling petitioners seek. The Third Circuit struck down the provision of 77 Pa. Stat. Ann. § 531(5) that authorizes delay in payment of disputed bills. Pet. App. 25a ("Under our holding today we * * * sever the 'unless' clause from § 531(5) of the Act."). If and when that ruling is reversed, insurers and employers will be able to resume the practice, as authorized by the legislature.

D. Respondents' Arguments On The Merits Are Unconvincing

The vehemence with which respondents contest reviewability becomes explicable once one considers their defense of the Third Circuit's holding. The few arguments respondents bother to make — the most notable aspect of their brief is its non-responsiveness — do nothing to undermine petitioners' analysis.

Respondents simply ignore our contention that injured workers lack a protected interest because they are "indirect" beneficiaries under *O'Bannon* v. *Town Court Nursing Center*, 447 U.S. 773 (1980). See Pet. Br. 32-35. Neither the respondents nor a single

one of their *amici* even cites *O'Bannon*, much less discusses its applicability to this case.[13]

Nor do respondents contest that withholding payment during disputes over workers' compensation coverage comports with traditional practice under state and federal law. See Pet. Br. 47-50. The only *amicus* in support of respondents to address the issue, the Pennsylvania Federation of Injured Workers, asserts that the widespread practice of the state and federal government should be disregarded because "workers' compensation statutes were adopted initially without regard for modern concepts of due process." Br. 17. That, however, begs the question, since "traditional practices" are the best evidence of what due process requires. Pet. Br. 47-48 (citing cases).

Respondents' contention that submission of a bill is not akin to an application for benefits is only marginally more responsive. Respondents assert that, because each named plaintiff has been found eligible for workers' compensation medical benefits (Resp. Br. 8 n.10), it follows that they are presumptively entitled to reimbursement for any and all care that they receive. *Ibid.*; see also *id.* at 1 (injured workers "have an undisputed property interest" in payment for disputed treatment); Br. Am. Cur. Pa. Trial Lawyers Ass'n *et al.* 8-9 (workers have "a legitimate claim of entitlement" to uninterrupted payment for medical care pending utilization review).

As we explained in our opening brief (at 35-38), however, this conclusion is erroneous. An injured employee's eligibility for workers' compensation benefits entitles him to reimbursement *only*

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[13] Respondents might be thought to address the *O'Bannon* distinction obliquely at 13 n.16, where they argue that they have a protected due process interest because provider "bills are merely the vehicle through which medical benefits are provided under the Act" and an injured worker's "treatment is ordinarily stopped" when bill payment is delayed. See also Resp. Br. 23-24. But that was true in *O'Bannon* as well, where Medicaid paid the nursing home directly on behalf of the patients and the "inevitable consequence" of suspension of Medicaid payments to the provider was "severe physical and emotional hardship" to some patients. 447 U.S. at 780, 784 & n.15.

for reasonable and necessary medical care. 77 Pa. Stat. Ann. § 531(1), (5). But determining whether medical care satisfies this standard cannot occur until the bill has been submitted or the provider or insurer has asked for pre-approval. Pet. Br. 37 & n.19. Until the insurer, employer, or utilization reviewer has decided that the care is reasonable and necessary, a worker has no vested entitlement to provider reimbursement.[14]

Finally, respondents' analysis of the competing interests under *Mathews* (at 21-24) does not withstand examination. Respondents seem oblivious to the need to control fraud and abuse in the medical field. They do not dispute that insurers are legally barred from recouping from the employee or the provider any payments made for unreasonable or unnecessary care. They do not dispute our contention that the decision below, if not reversed, would effectively negate the effects of utilization review and leave the system vulnerable to unscrupulous health care providers. They do not mention the Solicitor General's concern that the holding below would have similar disruptive effects for Medicare and Medicaid. Nor do they address our argument (at 41-43), echoed by the Solicitor General (U.S. Br. 27-28), that the incentives built into the current system make the risk of erroneous deprivation relatively slight. They ignore our citations to decisions of this Court upholding analogous systems in which payment of disputed bills is delayed pending resolution of the dispute. Pet. 45-47 (citing *United States Dep't of Labor* v. *Triplett*, 494 U.S. 715 (1990); *Heckler* v. *Ringer*, 466 U.S. 602, 619 (1984); *Schweiker* v. *McClure*, 456 U.S. 188 (1982)). None of these considerations seems to count in their analysis, but the due process balance cannot be conducted responsibly without attention to these issues.

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[14] Respondents are therefore incorrect when they assert (at 21) that "no one disputes that the challenged statute permitted a recognized property right to be disrupted without any pre-deprivation notice." We readily concede that, once a worker has been determined to be injured, he has a property interest in *reasonable and necessary* medical care; but he does not have a vested interest in reimbursement for *any particular course of treatment* until there has been a determination that it was reasonable and necessary. Accord U.S. Br. 21-24.

In our opening brief, we cited government statistics showing that almost 70% of the utilization reviews requested under the Act turned out to involve care that was unnecessary or unreasonable, at least in part, and that the procedures had produced significant savings. Pet. Br. 39-40, 43-44. Respondents do not challenge the accuracy of the statistics. Nevertheless, they argue (at 50 n.42) that this Court should not consider "numerous facts and statistics which were not in the record in the district court" because respondents' due process challenge was dismissed by the district court on a Rule 12(b)(6) motion. This Court, however, has frequently considered extra-record evidence in assessing the value of additional procedures, including government-compiled statistics of the type at issue here;[15] information gleaned from academic and scholarly sources;[16] and its own experience and common sense.[17] The statistics we cited are subject to judicial notice under Federal Rule of Evidence 201.[18]

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[15] See, *e.g.*, *M.L.B.* v. *S.L.J.*, 519 U.S. 102, 109 n.3 (1996); *Califano* v. *Yamasaki*, 442 U.S. 682, 697 (1979); *Califano* v. *Yamasaki*, No. 77-1511, Brief for Respondents 43-44, 46 (statistics considered over objection that they were outside the record); *Smith* v. *Organization of Foster Families for Equality and Reform*, 431 U.S. 816, 851 (1977); *Smith* v. *Organization of Foster Families for Equality and Reform*, Nos. 76-180, 76-183, 76-5193, 76-5200, Brief for State Appellants 20; *Richardson* v. *Perales*, 402 U.S. 389, 403 n.7 (1971); *Richardson* v. *Perales*, No. 108, October Term 1970, Brief for Petitioners 18 nn.7-8.

[16] See, *e.g.*, *Washington* v. *Harper*, 494 U.S. 210, 234 n.13 (1990); *Little* v. *Streater*, 452 U.S. 1, 7-8 (1981); *Parham* v. *J.R.*, 442 U.S. 584, 609 (1979); *Greenholtz* v. *Inmates of Nebraska Penal & Correctional Complex*, 442 U.S. 1, 14 (1979).

[17] See, *e.g.*, *Heller* v. *Doe*, 509 U.S. 312, 329-331 (1993); *Little*, 452 U.S. at 8; *Parham*, 442 U.S. at 609.

[18] See, *e.g.*, *United Steelworkers* v. *Weber*, 443 U.S. 193, 198 n.1 (1979); *Carey* v. *Population Servs. Int'l*, 431 U.S. 678, 690 n.8 (1977); *United States* v. *Bailey*, 97 F.3d 982, 985 (7th Cir. 1996); *United States* v. *Cecil*, 836 F.2d 1431, 1452 (4th Cir.) (noting "correct contention that courts may take judicial notice of official governmental reports and statistics"), cert. denied, 487 U.S. 1205 (1988); *Havens Steel Co.* v. *Randolph Eng'g Co.*, 813 F.2d 186, 189 (8th Cir. 1987); *Jamies* v. *Toledo Metro. Hous. Auth.*, 758 F.2d 1086, 1090 nn.3-4 (6th Cir. 1985).

Respondents accuse us of "grossly mischaracter[izing] the record" by describing the injured worker's interest in the challenged provision as involving "bills" — even though the statute they challenged uses precisely that terminology. Resp. Br. 23; compare 77 Pa. Stat. Ann. § 531(5). What is really at stake, according to respondents, is the provision of timely medical care. Resp. Br. 22 n.24 (citing *Stonebraker* v. *Workers' Comp. App. Bd.*, 641 A.2d 655, 659 (Pa. Commw. Ct. 1994)).[19] The fallacy in that argument was addressed in our opening brief (at 41-42).

Respondents seem to be suggesting that the workers' interests are especially harmed because they are prohibited from obtaining additional medical services with their own funds. See Resp. Br. 7, 24 & n.25. This suggestion is simply false. 77 Pa. Stat. Ann. §§ 531(3)(i) and 481(a), the provisions cited by respondents in support of this claim, state no such thing. Section 531(3)(i) states only that "a provider shall not require, request or accept payment for the treatment, accommodations, products or services in excess of one hundred thirteen per centum of [various prevailing charges]." Section 481(a), likewise, provides only that "[t]he liability of an employer under this act shall be exclusive and in place of any and all other liability to such employee * * * on account of any injury or death * * * or occupational disease." It is a stretch, to say the least, to read these provisions as precluding employees from voluntarily contracting for other treatment at their own expense. Although 34 Pa. Code § 127.211 and 77 Pa. Stat. Ann. § 531(7) forbid "balance billing" of patients for past treat-

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[19] Although respondents contend that the *Stonebraker* decision supports their balancing of interests under *Mathews*, its holding has been expressly repudiated since the enactment of Act 44. See *Albert Einstein Med. Ctr.* v. *Workers' Comp. App. Bd.*, 707 A.2d 611, 616 & n.11 (Pa. Commw. Ct. 1998) (*Stonebraker* was legislatively superseded by Act 44's utilization review procedures, which minimized the risk that an injured employee will be denied necessary medical care "by establishing a swift and efficient means by which the reasonableness and necessity of medical bills could be determined").

ment determined to be unreasonable or unnecessary,[20] they do not make it unlawful for a worker who knows that such treatment is not covered by workers' compensation to pay for it *prospectively*, at her own expense and on her own initiative.[21] To our knowledge, the law has never been applied in the manner suggested by respondents, and such an interpretation would raise serious constitutional questions. Cf. *Griswold* v. *Connecticut*, 381 U.S. 479 (1965); *Cruzan* v. *Missouri Dep't of Health*, 497 U.S. 261 (1990).

Moreover, as the district court in this case recognized, nothing in the statute "requires that the medical provider stop giving the challenged treatment." Pet. App. 70a n.4. At least half of the named plaintiffs continued to receive disputed care after a request for utilization review. Pet. Br. 42. Respondents' assertion that deferral of payment for disputed care is tantamount to a prohibition on the provision of that care is baseless.

In short, respondents' sparse discussion of the due process balance disregards vital considerations of cost containment and relies on misinterpretations of the law and the record.

CONCLUSION

For the foregoing reasons, and those stated in our opening brief, the judgment of the court of appeals should be reversed.

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[20] "Balance billing" is the practice of collecting from a patient the difference between a physician's charge for medical treatment and the amount reimbursed the patient's insurer. See *Pennsylvania Dental Ass'n* v. *Medical Serv. Ass'n*, 815 F.2d 270, 272 (3d Cir.), cert. denied, 484 U.S. 851 (1987).

[21] The quotation from David Weyl at Resp. Br. 24 n.25, is consistent with this interpretation. Unreasonable or unnecessary care is not "provided under the Act." Medicare draws the same distinction. Although Medicare prohibits "balance billing" patients, a patient who is given advance notice that medical treatment might be deemed unreasonable or unnecessary may agree to pay out-of-pocket for the treatment, and the provider may bill the patient for the care. Statement by Administrator, Health Care Financing Administration, [1998-1 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 46,018, at 57,031 (Dec. 30, 1997).

Respectfully submitted.

ROBERT MCL. BOOTE
BURT M. RUBLIN
Ballard Spahr Andrews & Ingersoll, LLP
1735 Market Street
Philadelphia, PA 19103
(215) 665-8500

Counsel for All Petitioners Except Donegal Mut. Ins. Co.

ROBERT E. KELLY, JR.
Duane, Morris, Heckscher, LLP
305 N. Front Street
Harrisburg, PA 17108
(717) 237-5500

Counsel for Donegal Mut. Ins. Co.

MICHAEL W. MCCONNELL
Counsel of Record
ALAN E. UNTEREINER
ROY T. ENGLERT, JR.
STEFFEN N. JOHNSON
SHARON SWINGLE
Mayer, Brown & Platt
190 South La Salle Street
Chicago, IL 60603
(312) 782-0600

Counsel for All Petitioners

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1998

AMERICAN MANUFACTURERS MUTUAL INSURANCE CO., *et al.*,
Petitioners,

v.

DELORES SCOTT SULLIVAN, *et al.*,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Third Circuit

---

BRIEF *AMICUS CURIAE* ON BEHALF OF THE NATIONAL ASSOCIATION OF WATERFRONT EMPLOYERS, MASTER CONTRACTING STEVEDORE ASSOCIATION OF THE PACIFIC COAST, AND SIGNAL MUTUAL INDEMNITY ASSOCIATION, LTD., AS *AMICI CURIAE* IN SUPPORT OF PETITIONERS

F. EDWIN FROELICH
Counsel of Record
CHARLES T. CARROLL
WILCOX, CARROLL & FROELICH, PLLC
2011 Pennsylvania Avenue, N.W.
Washington, D.C. 20006
(202) 296-3005
Counsel for Amici Curiae

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INTEREST OF *AMICI CURIAE*

The National Association of Waterfront Employers ("NAWE") is a not for profit tax-exempt trade association organized under the laws of the District of Columbia.[1]

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[1] Pursuant to Supreme Court Rule 37.3, a blanket letter of consent on behalf of both Petitioners and Respondents has been filed with the Clerk of the Court on October 22, 1998. Pursuant to Supreme Court Rule 37.6, *amici curiae* state that no counsel for any party authored the brief in whole or in part and no person or entity, other than the *amici curiae*, its members, or its counsel, made a monetary contribution to the preparation or submission of this brief.

NAWE's 35 members are private sector stevedores and marine terminal operators who operate in over 100 ports in the United States on all three coasts, the Great Lakes, and the Commonwealth of Puerto Rico. Every NAWE member company employs longshore labor engaged in maritime employment subject to the federal Longshore and Harbor Workers' Compensation Act, 33 U.S.C. § 901 *et seq.* ("LHWCA"), other than those members operating in Puerto Rico.

The Master Contracting Stevedore Association of the Pacific Coast ("MCSA") is a not-for-profit trade association whose 15 member private sector companies provide contract stevedoring services in all principal ports in the states of California, Oregon and Washington, and provide substantially all the maritime terminal and stevedoring services performed by private contractors to ocean-going vessels calling at ports in these states. Every MCSA member company employs longshore labor engaged in maritime employment subject to the federal LHWCA.

Signal Mutual Indemnity Association, Ltd. is the largest self-insurance facility authorized by the Secretary of Labor to secure the benefits payable under the LHWCA on a non-profit and cost effective basis for selected employers over the long term.

A district court in the Third Circuit has now extended the state action doctrine to cover private employers making benefit decisions under the federal LHWCA. *See Kreschollek v. Southern Stevedoring*, Civil No. 93-3903 (JHR), Order (D.N.J., Sept. 30, 1997). NAWE is a party to that litigation on behalf of its member companies. *Kreschollek* was brought under the Fifth Amendment Due Process clause and involves a facial challenge to a federal statute and federal regulations brought, in part, against a private entity, Southern Stevedoring Company.

Amici submit that this Court's answer to the questions accepted for review will have a direct effect on the 27,000+ benefit decisions made each year by self-insured employers and/or insurance carriers subject to the

LHWCA. The self-insured employer-members of NAWE and the MCSA, along with all of the members of Signal Mutual Indemnity Association, Ltd., together comprise a substantial portion of the employers subject to the jurisdiction of the LHWCA. These employers will be faced with making many of these financially burdensome decisions.

Because *Amici* believe that the answer to the first question should be dispositive and will address the source of confusion in the lower courts, *Amici* have limited this brief to addressing that question.[2]

SUMMARY OF ARGUMENT

Amici believe that this Court need look no further than its holdings in *Blum v. Yaretsky*, 457 U.S. 991 (1982) and *Jackson v. Metropolitan Edison Co.*, 419 U.S. 345 (1974) to find that the Petitioners in this case are not state actors. However, *Amici* believe that this Court should not end its inquiry there, but instead should take this opportunity to review the confused state action doctrine in its entirety.

The "traditional government function" and "government coercion" theories of state action are not the source of the confusion, at least to the extent those theories are considered distinct lines of cases. The confusion arises from the "government cooperation" theory of state action when viewed through the prism of the *Burton v. Wilmington Parking Authority*, 363 U.S. 715 (1961) fact-dependent inquiry. Not surprisingly, when turned loose with a concept as nebulous as government cooperation or participation and told that it is a fact-bound inquiry, the lower courts are bound to reach some erroneous conclusions, as evidenced by the decision below.

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[2] The first question presented is "Whether private companies providing workers' compensation insurance to private employers become 'state actors' for purposes of the Due Process Clause when they elect to use a state-authorized utilization review procedure."

This case should be characterized as a "government participation" type of state action case. *Amici* urge this Court to review its prior holdings in this area and to finally establish a clear test for what constitutes sufficient government participation to invoke the state action doctrine.

ARGUMENT

I. THE CONSTITUTION GIVES PRIVATE CITIZENS THE FUNDAMENTAL RIGHT NOT TO BE SUBJECT TO THE SAME RESTRICTIONS IMPOSED ON STATE ACTORS

The Constitution authorizes a national government, while at the same time confining the actions of that national government, with regard to certain individual liberties and other specified matters. *Edmonson v. Leesville Concrete Co.*, 500 U.S. 614, 619 (1991). The Constitution also confines some actions of the states. *Id.* These same restrictions do not apply to private citizens.[3]

> With a few exceptions, such as the provisions of the Thirteenth Amendment, constitutional guarantees of individual liberty and equal protection do not apply to the actions of private entities. *National Collegiate Athletic Assn. v. Tarkanian*, 488 U.S. 179, 191 (1978). This fundamental limitation on the scope of constitutional guarantees "preserves an area of individual freedom by limiting the reach of the federal law" and "avoids imposing on the State, its agencies or officials, responsibility for conduct for which they cannot fairly be blamed." *Lugar v. Edmondson Oil Co.*, 457 U.S. 922, 936-937 (1982). One great object of the Constitution is to permit citizens to structure their private relations as they choose subject only to the constraints of statutory or decisional law.

Edmonson, 500 U.S. at 619.

[3] *Amici* use the phrase "private citizen" in its broadest sense to encompass individuals, as well as other private entities such as partnerships, corporations, organizations, etc.

To the extent the federal courts expand the "state action doctrine" to cover private conduct, they deny private citizens a fundamental right guaranteed under the Constitution. The constitutional right of private citizens to not be subject to the constitutional constraints imposed on government is as important a fundamental right as are the rights to free speech, free association and counsel. Such a fundamental right should not be limited by the courts without a sound textual and public basis for that limitation.

II. THE CURRENT STANDARD FOR WHAT CONSTITUTES STATE ACTION MUST BE REPLACED

The federal courts have struggled for more than one hundred years with the question of where the governmental sphere ends and where the private sphere begins. *See The Civil Rights Cases*, 109 U.S. 3 (1883). This Court has articulated a number of approaches to this constitutional question. In *Burton v. Wilmington Parking Authority*, 365 U.S. 715, 722 (1961), this Court held that "[o]nly by sifting facts and weighing circumstances can the nonobvious involvement of the State in private conduct be attributed its true significance."

In *Edmonson*, this Court reiterated that the determination of what constituted state action was a "fact-bound inquiry." *Edmonson*, 500 U.S. at 621. *Edmonson* held that two questions must be answered:

> We asked first whether the claimed constitutional deprivation resulted from the exercise of a right or privilege having its source in state authority, and second, whether the private party charged with the deprivation could be described in all fairness as a state actor.

Edmonson, 500 U.S. at 620 (internal citations omitted).

The problem inherent in the "fact-bound" *Burton* inquiry is that no decision is ever controlling on future cases unless the facts presented are exactly the same.

The *Burton* approach leaves each succeeding court free to assess the equities anew, as the Third Circuit Court of Appeals has done in the present case. In the modern, highly regulated world, almost any private commercial or employment-based transaction that contemplates a state established dispute resolution process can be construed as "state action." Such an approach destroys the fundamental constitutional freedom of private citizens not to be subject to the same constitutional burdens as government.

As long as the *Burton* approach is alive, each state action decision of this Court is subject to being "treated like a restricted railroad ticket, 'good for this day and train only.'" *County of Washington, Oregon v. Gunther*, 452 U.S. 161, 183 (1981) (Rehnquist, J., dissenting), (quoting *Smith v. Allwright*, 321 U.S. 649, 669 (1944)) (Roberts, J., dissenting). Such an approach leaves private citizens in the dark as to what private conduct may subsequently be held by a court to be state action subject to constitutional scrutiny. As the law currently stands, citizens have no basis for predicting when their apparently private conduct might subject them to civil liability or even, in theory, to criminal liability. See 42 U.S.C. § 1983; 18 U.S.C. § 241 *et seq.*

This Court has acknowledged the problem, describing state action decisions as "difficult terrain," *Lebron v. National Railroad Passenger Corp.*, 513 U.S. 374, 378 (1995), and as "not a model of consistency." *Id.* at 378 (quoting *Edmonson*, 500 U.S. at 632) (O'Connor, J., dissenting). Indeed, this Court alluded to the problem in 1982, when it said:

> [T]he Court has articulated a number of different factors or tests in different contexts * * * Whether the different tests are actually different in operation or simply different ways of characterizing the necessarily fact-bound inquiry that confronts the Court in such a situation need not be resolved here.

Lugar, 457 U.S. at 939.

The state action doctrine has now reached its illogical extreme in the lower courts—i.e., facial challenges to statutes and regulations being brought against private parties.[4] *Amici* respectfully submit that the time is ripe for this Court to revisit the standard used to evaluate "state action" and to establish a clearer and more definite test.

III. THE PETITIONERS SHOULD NOT "BE DESCRIBED IN ALL FAIRNESS AS A STATE ACTOR"

In *Edmonson*, this Court described the second aspect of the "state action" inquiry as "whether the private party charged with the deprivation could be described in all fairness as a state actor." *Edmonson*, 500 U.S. at 620. *Edmonson* went on to proscribe three areas of judicial examination relevant to answering this question:

> Our precedents establish that, in determining whether a particular action or course of conduct is governmental in character, it is relevant to examine the following: the extent to which the actor relies on governmental assistance and benefits; whether the actor is performing a traditional governmental function; and whether the injury caused is aggravated in a unique way by the incidents of governmental authority.

Edmonson, 500 U.S. at 621-22 (internal citations omitted). Consistent with *Edmonson*, this Court's decisions on "state action" can be separated into three distinct categories: (1) traditional government function cases; (2) government coercion cases; and (3) government participation cases.

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[4] While the Third Circuit did not characterize Respondents' challenge in this case, it appears to be a facial challenge. *Sullivan v. Barnett*, 139 F.3d 158 (3rd Cir. 1998). *See also Keschollek v. Southern Stevedoring Co.*, 78 F.3d 868 (3rd Cir. 1996) (facial challenge to federal LHWCA and its associated regulations brought against a private stevedoring company).

As discussed in detail below, *Amici* believe that the state-action cases should be read as describing three distinct *independent categories* of state action, as opposed to *interdependent factors* to be considered collectively. It is illogical to treat these distinct types of state action as ingredients for a mixing bowl—take a little bit of "almost traditional government function," add it to a pinch of "approaching government coercion," then sprinkle on a smidgen of "government participation," mix it all together, and *voila*, out comes state action. This mixing bowl approach is a recipe for disaster. It can only lead to the type of confusion that now exists in the lower courts, as evidenced by the Court of Appeals in this case.

Amici submit that no amount of government coercion or government participation can transform a function that is not a traditional government function into a function that is a traditional government function for state-action purposes. In the same light, if government coercion of private actions is sufficient to create state action, that state action exists regardless of whether the private action involves a traditional government function or not. That is not to say that analysis of all three lines of cases will not be necessary under some circumstances or that a given case might not involve more than one type of state action. However, each of these three types of state action should stand on their own, each independent of the other.

A. Petitioners Should Not "Be Described In All Fairness As A State Actor" Because Petitioners Were Not Performing A Traditional Government Function

In a long line of cases, this Court has found that some functions are so public in their nature that when performed by private actors, the private actors cannot avoid the constitutional responsibilities of state actors. *Nixon v. Condon*, 286 U.S. 73 (1932) (election); *Smith v. Allwright*, 321 U.S. 649 (1944) (election); *Marsh v. State of Alabama*, 326 U.S. 501 (1946) (company town);

Terry v. Adams, 345 U.S. 461 (1953) (election); *Evans v. Abney*, 396 U.S. 435 (1970) (municipal park).

Amici submit that this Court's jury selection cases should also be characterized as traditional government function cases since providing a jury is a function traditionally performed exclusively by government. *Edmondson*, 500 U.S. at 624-25 (peremptory challenges to jury members in civil litigation); *Georgia v. McCollum*, 505 U.S. 42 (1992) (defendant's challenge to jury members in criminal litigation).

The traditional government function line of cases appears to be supported by the sound public policy that a state should not be able to circumvent its constitutional obligations by allowing private individuals to act in place of the government. When a government allows private parties to assume functions that are traditionally the exclusive parlance of government, the private party steps into the shoes of government. Under such circumstances, both the government and the private party are on notice that they will be held to the constitutional standards of state actors.

To meet the test for a traditional government function, the activity must be "traditionally the *exclusive* prerogtive" of government. *San Francisco Arts & Athletics, Inc. v. U.S. Olympic Comm.*, 483 U.S. 522, 544 (1987) (citations omitted) (emphasis in original). This Court has found that a number of private actions do not fall within the very narrow bounds of a traditional government function. *Jackson v. Metropolitan Edison Co.*, 419 U.S. 345 (1974) (utility services); *Hudgens v. NLRB*, 424 U.S. 507 (1976) (shopping centers); *Rendell-Baker v. Kohn*, 457 U.S. 830 (1982) (private school); *San Francisco Arts & Athletics, Inc. v. U.S. Olympic Comm.*, 483 U.S. 522 (1987) (U.S. Olympic Committee).

Of these cases, the *Jackson* decision is perhaps the most instructive as to how narrow the "traditional government

function" test should be construed. The fact that a private action is heavily regulated or is performed by a monopolist does not make the private action a government function, even if that monopolist is so powerful as to impose its will on the state. *National Collegiate Athletic Ass'n v. Tarkanian*, 488 U.S. 179, 198-99 (1988).

> All of petitioner's arguments taken together show no more than that Metropolitan was a heavily regulated, privately owned utility, enjoying at least a partial monopoly in the providing of electrical service within its territory, and that it elected to terminate service to petitioner in a manner which the Pennsylvania Public Utility Commission found permissible under state law. Under our decision this is not sufficient to connect the State of Pennsylvania with respondent's action so as to make the latter's conduct attributable to the State for purposes of the Fourteenth Amendment.

Jackson, 419 U.S. at 358. The fact that a private activity could be or has been performed by government does not make that private activity an essential government function. *Id.* at 354 n.9. Finally, the fact that a private activity affects a public interest does not make it an essential government function. *Id.* at 354.

In the case at hand, no colorable argument can be made that compensating private individuals for injuries that are sustained in a private workplace is "traditionally the *exclusive* prerogative" of government. *San Francisco Arts*, 483 U.S. at 544. While it is true that this private dispute—like almost all private disputes—has traditionally been mediated by government, government mediation alone cannot transform a private dispute into a traditional government function. *Jackson*, 419 U.S. at 357.

Because the Petitioners were not performing a traditional state function, their private decisions concerning

the provision of workers' compensation benefits can only be considered state action if their decisions were the result of government coercion or government assistance.

B. Petitioners Should Not "Be Described In All Fairness As A State Actor" Because Petitioners Were Not Coerced By The Government Into Acting

In a second line of cases, this Court has held that private parties are state actors when they undertake actions under government compulsion. *Shelley v. Kraemer*, 334 U.S. 1 (1948) (court enforced restrictive property covenant); *Peterson v. City of Greenville*, 373 U.S. 244 (1963) (compulsory segregation of private eating establishment); *Lombard v. State of Louisiana*, 373 U.S. 267 (1963) (police chief's official command directed continuance of segregated service); *Robinson v. State of Florida*, 378 U.S. 153 (1964) (compulsory segregation of restroom in private facility); *Moose Lodge No. 107 v. Irvis*, 407 U.S. 163 (1972) (state law requiring compliance by club with provisions of its constitution and bylaws containing racially discriminatory provisions); (*Skinner v. Railway Labor Executives' Ass'n*, 489 U.S. 602 (1989) (mandatory drug testing).

The government coercion line of cases also appears to be supported by sound public policy. Government should not be able to circumvent its constitutional obligations by compelling private individuals to act on the government's behalf. Government should not be able to do indirectly through private surrogates what it cannot do directly under the Constitution. The "traditional government function" theory places the private party in the shoes of the government, while the "government coercion" theory places the government in the shoes of the private party. Again, when government orders private action, both the government and the private party are on notice that they will be held to the constitutional standards of state actors.

For government coercion to exist, the government must do significantly more than authorize the private conduct, *Flagg Bros., Inc. v. Brooks*, 436 U.S. 149 (1978) (private action authorized by state law), or subsequently ratify the decision, *Jackson v. Metropolitan Edison Co.*, 419 U.S. 345, 357 (1974):

> Approval by a state utility commission of such a request from a regulated utility, where the commission has not put its own weight on the side of the proposed practice by ordering it, does not transmute a practice initiated by the utility and approved by the commission into 'state action.' At most, the Commission's failure to overturn this practice amounted to no more than a determination that a Pennsylvania utility was authorized to employ such a practice if it so desired. Respondent's exercise of the choice allowed by state law where the initiative comes from it and not from the State, does not make its action in doing so 'state action' for purposes of the Fourteenth Amendment.

For government coercion to exist, the government must dictate or at least actively weigh-in in favor of the course of action.

In the case at hand, no colorable argument can be made that the private workers' compensation carriers were coerced into the actions that were taken. Quite the contrary. The decision as to whether to challenge medical services as reasonable and necessary was purely discretionary. The government expressed no view and had no interest in this private decision. The fact that the private carriers' discretionary decisions were ultimately subject to government review in no way converts those private discretionary decisions into government coerced actions.

Because the Petitioners were not coerced into action by government, their private decision concerning workers' compensation benefits can only be considered state action if the decisions were the result of significant government participation.

C. Petitioners Should Not "Be Described In All Fairness As A State Actor" Because Petitioners Were Not Acting In Concert With the Government

This Court has stated, but has rarely held, that private, discretionary actions that do not involve traditional governmental functions and have not been coerced, nonetheless can rise to the level of state action if the government is sufficiently entangled in the decision:

> We have held once, *Burton v. Wilmington Parking Authority*, 365 U.S. 715 (1961), and said many times, that actions of private entities can sometimes be regarded as governmental action for constitutional purposes.

Lebron v. National Railroad Passenger Corp., 513 U.S. 374, 378 (1995). With the exception of this Court's holding in *Burton*, the other participation cases appear to be limited to situations where a government official was directly involved in assisting one private party to obtain the private property of another. *Lugar v. Edmondson Oil Co.*, 445 U.S. 922 (1982);[5] *Tulsa Professional Collection Services, Inc. v. Pope*, 485 U.S. 478 (1988) (state appointed trustee, complying with court ordered notice requirements);[6] *Soldal v. Cook County, Illinois*, 506 U.S. 56 (1992) (deputy sheriff assists with the private seizure of property).

On the other hand, it is easy to identify a list of cases that did not involve sufficient government entanglement

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[5] It is difficult to reconcile *Lugar* with this Court's more recent holding in *National Collegiate Athletic Ass'n v. Tarkanian*, 488 U.S. 179 (1988), where the state had significantly more discretion in its actions, other than on the grounds that *Lugar* involved real property while *Tarkanian* involved employment.

[6] While *Pope* appears to have been characterized as an entanglement case, it is hard to identify the discretion in the conduct since the trustee was selected by the court, and the type of notice was then proscribed by the court pursuant to state law. *Pope*, 485 U.S. at 487-88. Therefore, *Pope* could be characterized as a government compulsion case.

to constitute state action. *Moose Lodge No. 107 v. Irvis*, 407 U.S. 163 (1972) (liquor license for private club); *Flagg Bros., Inc. v. Brooks*, 436 U.S. 149 (1978) (warehouseman's sale pursuant to the UCC of entrusted goods); *Blum v. Yaretsky*, 457 U.S. 991 (1982) (transfer of Medicaid nursing home patients when state paying for services); *National Collegiate Athletic Ass'n v. Tarkanian*, 488 U.S. 179 (1988) (private organization ordered discipline of state employee).

This Court has consistently held that private use of government-sanctioned remedies or procedures do not rise to the level of state action. *Edmonson v. Leesville Concrete Co.*, 500 U.S. 614, 622 (1991); *Pope*, 485 U.S. at 485; *Lugar*, 457 U.S. at 922. Furthermore, state action does not exist merely because the state provides some general support.

> Since state-furnished services include such necessities of life as electricity, water, and police and fire protection, such a holding would utterly emasculate the distinction between private as distinguished from state conduct set forth in *The Civil Rights Cases, supra*, and adhered to in subsequent decisions.

Moose Lodge, 407 U.S. at 173. And as discussed above, the government regulation of conduct, and even a government granted monopoly does not transform private conduct into state action. *Jackson v. Metropolitan Edison Co.*, 419 U.S. 345, 350 (1974). The Government may subsidize private entities without assuming constitutional responsibility for their actions. *San Francisco Arts & Athletics, Inc. v. U.S. Olympic Comm.*, 483 U.S. 522, 544 (1987); *Blum v. Yaretsky*, 457 U.S. 991, 1011, (1982); *Rendell-Baker v. Kohn*, 457 U.S. 830, 840 (1982).

In the case at hand, there is no evidence of the type of government participation that this Court has required to support a holding of state action. The Petitioners have done little more than execute a purely discretionary act

in which the state expressed no opinion and had no interest. Petitioners' discretionary actions were taken in accordance with state law and there is no evidence that the state law was more extensive than the law in *Jackson* (regulated private utility) or *Blum* (regulated nursing home). Even if the decision here were made in a more highly regulated environment, that fact still would not make the private decision state action. *Jackson*, 419 U.S. at 350.

D. A Private Party Who Acts In Good Faith In Accordance With The Laws As Written By The Government Should Not "Be Described In All Fairness As A State Actor"

As a bottom line, there appears to be no basis under this Court's prior holdings to conclude that the actions of the Petitioner are state actions. Nevertheless, a lower court is free to reach a different conclusion as long as each state action decision of this Court is subject to being "treated like a restricted railroad ticket, 'good for this day and train only.'" *County of Washington, Oregon v. Gunther*, 452 U.S. 161, 183 (1981) (Rehnquist, J., dissenting) (quoting *Smith v. Allwright*, 321 U.S. 649, 669 (1944)) (Roberts, J., dissenting).

Amici respectfully submit that this Court should go beyond overturning the Court of Appeals' decision in this case. It should clarify the constitutional tests for determining what constitutes state action. *Amici* urge two clarifications. First, as previously stated, *Amici* urge this Court to clarify that "traditional government function," "government coercion" and "government participation" are three distinct and separate types of state action. These types of state action are not factors to be sifted, weighed and mixed together.

Second, *Amici* urge this Court to adopt a clear test for what constitutes state action. *Amici* believe that the problem with the current state action test stems from the

vagueness of the "government participation" concept, as opposed to the "traditional government function" and "government coercion" concepts of state action.

The test for what constitutes sufficient "government participation" to trigger the state action doctrine should encompass three basic principles: (1) the government and the private party must act contemporaneously; (2) the government and private party must share a common purpose in their actions; and (3) there should be no adequate remedy against the government itself.

Such an approach would clearly exclude all private efforts to comply with government legislative and regulatory requirements from consideration as "government participation" [7] because they do not occur contemporaneously and usually do not have the same purpose. This approach would also exclude government provided dispute resolution as a potential source of "state action."

As previously discussed, the public policy behind the "traditional government function" and "government coercion" holdings are readily apparent. The same is not true for the "government participation" theory outside the limited context of property seizure. Unlike the "traditional government function" and "government coercion" theories of state action, the "government participation" theory would appear to have little role in deterring government entities from attempting to circumvent their constitutional obligations.

Applying the "government participation" theory of state action outside the narrow confines outlined above creates the very real possibility of punishing private citizens for the "crime" of complying with the law, as in the present case. If the test for "government participation" is not clearly drawn, a private party, acting in good faith and in accordance with laws duly adopted by the govern-

[7] Such actions could still be considered under the tests for "traditional government function" and "government coercion."

ment, may nonetheless be subject to civil and, in theory, criminal liability, court costs, and in some cases attorney's fees. This liability may vest without any prior notice that the private party's actions were sanctionable.

Furthermore, the "government participation" theory of state action is, by and large, unnecessary. To the extent a private party believes that a government statute or regulation violates fundamental constitutional rights, that private party can always bring a challenge against the government that wrote the law in the form of either a facial or an as applied challenge. The government that wrote the law is in the position to repeal, amend or clarify the law, if necessary. A private party defendant can take none of these actions. For this reason, when a remedy is available against the government that wrote a statute or regulation, it can never be fair to hold a private citizen responsible for the government's action.

In response to the Court's inquiry into "whether the private party charged with the deprivation could be described in all fairness as a state actor?" *Edmonson v. Leesville Concrete Co.*, 500 U.S. 614, 620 (1991), *amici* respectfully submit that the answer must be an emphatic "no" when the private actor is doing nothing more than complying in good faith with the laws as written by government entities.

CONCLUSION

For the reasons stated herein, the judgment of the United States Court of Appeals for the Third Circuit should be reversed.

Respectfully submitted,

F. EDWIN FROELICH
Counsel of Record
CHARLES T. CARROLL
WILCOX, CARROLL & FROELICH, PLLC
2011 Pennsylvania Avenue, N.W.
Washington, D.C. 20006
(202) 296-3005
Counsel for Amici Curiae

No. 97-2000

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AMERICAN MANUFACTURERS MUTUAL INSURANCE COMPANY, *et al.*,
Petitioners,
v.
DOROTHY SCOTT SULLIVAN, *et al.*,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Third Circuit

BRIEF OF *AMICI CURIAE* AMERICAN INSURANCE ASSOCIATION, ALLIANCE OF AMERICAN INSURERS, NATIONAL ASSOCIATION OF INDEPENDENT INSURERS, INSURANCE FEDERATION OF PENNSYLVANIA, CALIFORNIA WORKERS' COMPENSATION INSTITUTE, STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY, NATIONAL ASSOCIATION OF MANUFACTURERS, NATIONAL COUNCIL OF SELF-INSURERS, UWC-STRATEGIC SERVICES ON UNEMPLOYMENT & WORKERS' COMPENSATION, MICHIGAN SELF-INSURERS' ASSOCIATION, PENNSYLVANIA MANUFACTURERS ASSOCIATION, PENNSYLVANIA CHAMBER OF BUSINESS AND INDUSTRY, PENNSYLVANIA SELF-INSURERS' ASSOCIATION, PENNSYLVANIA DEFENSE INSTITUTE AND PENNSYLVANIA RETAILERS' ASSOCIATION IN SUPPORT OF PETITIONERS

MARK F. HORNING
Counsel of Record
SHANNEN W. COFFIN
GWENDOLYN PROTHRO
STEPTOE & JOHNSON LLP
1330 Connecticut Avenue, N.W.
Washington, D.C. 20036
(202) 429-8126
Counsel for Amici Curiae

WILSON - EPES PRINTING CO., INC. - 789-0096 - WASHINGTON, D.C. 20001

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INTEREST OF THE *AMICI*

Amici curiae respectfully submit this brief in support of the petitioners.[1] *Amici curiae* American Insurance Association, Alliance of American Insurers and National Association of Independent Insurers are insurance industry trade associations whose member companies write a substantial portion of the workers' compensation insurance written nationally, including in Pennsylvania, the state in which this case arose. *Amicus curiae* State Farm Mutual Automobile Insurance Company writes automobile and homeowners' insurance in Pennsylvania and throughout the country. *Amici curiae* National Association of Manufacturers, National Council of Self-Insurers, UWC-Strategic Services on Unemployment & Workers' Compensation, Insurance Federation of Pennsylvania, California Workers' Compensation Institute, Michigan Self-Insurers' Association, Pennsylvania Manufacturers' Association, Pennsylvania Chamber of Business and Industry, Pennsylvania Self-Insurers' Association, Pennsylvania Defense Institute and Pennsylvania Retailers' Association are all trade, advocacy or research organizations that, among other things, represent the interests of employers, both those that purchase workers' compensation coverage from insurers and those that self-insure.

Amici have a substantial interest in the issues presented in this case for two reasons. *First*, the decision of the Third Circuit Court of Appeals subjects insurers and self-insured employers to liability for damages under 42 U.S.C. § 1983 when they handle claims disputes arising from their private contracts of workers' compensation insurance and self-insurance plans. *Second*, the Third Circuit's rul-

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[1] Pursuant to Supreme Court Rule 37.6, *amici curiae* state that no counsel for any party to this dispute authored this brief in whole or in part and no person or entity, other than *amici curiae* and their member companies, made a monetary contribution to the preparation or submission of this brief. Most of the insurance company petitioners are members of one of the *amici* insurance industry trade associations.

ing strikes down an important legislative reform of the workers' compensation system in Pennsylvania and threatens to undo similar reforms in other states designed to prevent medical care fraud and overutilization.

Based on *amici*'s familiarity with workers' compensation insurance and self-insurance, and with state regulation of both, this brief addresses the need for a state action standard clearly differentiating the regulated but discretionary private conduct of insurers and employers from the actions of the state itself.[2]

SUMMARY OF ARGUMENT

The standard workers' compensation insurance policy used in Pennsylvania (and elsewhere) obligates the insurer to pay only for medical treatment that is "reasonable and necessary." In 1993, in order to combat fraud and overtreatment by medical care providers, Pennsylvania enacted a law to permit insurers to seek "utilization review" of disputed treatment by independent physicians and other healthcare specialists and, pending such review, to withhold payment of bills submitted for the disputed treatment. The insurer has complete discretion whether to invoke this "self-help" remedy for enforcement of contractual limitations on coverage. There is no requirement that the insurer obtain advance state approval; its self-initiated decision to suspend payment is not subjected to any subsequent state review of a substantive nature; and its decision is not enforced by any state official.

The Third Circuit Court of Appeals nevertheless held that the insurers' privately-initiated decisions should be attributed to the state, for essentially three reasons: (1) Private insurers perform a public function because the payment of workers' compensation benefits is a "uniquely governmental obligation"; (2) insurers are in a "symbiotic relationship" with the state because they help administer a system of state "entitlements"; and (3) the state "actively encourages" the insurers' temporary withholding of payment for medical bills by authorizing it. *Sullivan v. Barnett*, 139 F.3d 158, 167-70 (3d Cir. 1998). Each of these rationales for converting the discretionary judgments of privately-owned insurers in claims disputes into state action should be rejected. They go far beyond the boundaries of this Court's "public function," "symbiotic relationship" and "active encouragement" tests for attributing the conduct of regulated businesses to the state:

"Government Function" Test: The "public function" test treats a private party as a state actor only when it performs activities traditionally undertaken *exclusively* by the state as sovereign. The payment of workers' compensation benefits historically has never been a state function at all, let alone an exclusive one. The payment obligation has always belonged to the employer, not the state. The enactment of workers' compensation laws earlier in this century did not shift any payment obligation from the state to the employer (or insurer); it merely changed the standard governing that obligation from negligence to no-fault.

"Symbiotic Relationship" Test: Nor does the insurer's status as a regulated business place it in a "symbiotic relationship" with the state or make it a "joint participant" in state action. "The mere fact that a business is subject to state regulation does not by itself convert its action into that of the State for purposes of the Fourteenth Amendment. . . . Nor does the fact that the regulation is extensive and detailed . . . do so." *Jackson v. Metropolitan Edison Co.*, 419 U.S. 345, 350 (1974) (footnote and citations omitted). A "symbiotic relationship" exists between a state government and a private business only where there is some financial interdependency, state assistance or mutual benefit, which is utterly lacking in the

[2] All parties have given blanket consent to the filing of all *amicus* briefs in this case, in letters of consent filed with the Office of the Clerk of this Court.

arms' length relationship between state officials and the workers' compensation insurers they regulate.

"Compulsion" or "Active Encouragement" Test: This Court has attributed the conduct of regulated private businesses to the state only where the state regulation so broadly eliminates the "private choice" or business discretion of the regulated company that the state law, in effect, compels, coerces, enforces or controls the private action. This limitation arises from the central purpose of the state action doctrine: "[T]o assure that constitutional standards are invoked only when it can be said that the State is *responsible* for the specific conduct of which the plaintiff complains." *Blum v. Yaretsky*, 457 U.S. 991, 1004 (1982) (emphasis in original).

Neither the Pennsylvania utilization review statute nor the actions of Pennsylvania workers' compensation regulators compelled, coerced, enforced or even actively encouraged insurer decisions to suspend payment of provider bills pending utilization review. The statute merely authorized insurers to invoke a "self help" remedy inherent in any private contractual relationship—a refusal to provide contractual benefits pending resolution of a dispute about the scope of the contractual obligation. Pennsylvania merely authorized the insurer to elect to work out an insurance coverage dispute by private means *without* the need for significant state involvement.

The state's only role in the claims dispute is to require the insurer to make a notice filing—after the decision to withhold payment already has been made—formally requesting referral of the dispute to utilization review, a request automatically granted if it meets procedural filing requirements. The state's mere acquiescence in the insurer's privately-initiated decision falls far short of the "coercion," "significant encouragement" or "active assistance" that is required for imputing a private party's decision to the state.

The Third Circuit's expansionist state action standards should also be rejected because they invite federal judicial regulation of private insurance transactions, placing insurers in the dilemma of complying with conflicting federal and state regulatory rules. Such federal intervention in state-regulated insurance markets and preemption of state laws—such as the Pennsylvania reform nullified in this case—would be contrary to the congressionally-mandated policy of federal deference to state insurance regulation expressed in the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-15.

ARGUMENT

I. THE INSURER SUSPENSIONS OF PAYMENT TO MEDICAL CARE PROVIDERS WERE DISCRETIONARY AND PRIVATELY-INITIATED DECISIONS TO USE A PRIVATE REMEDY TO ENFORCE CONTRACTUAL RESTRICTIONS ON INSURANCE COVERAGE

Workers' compensation insurance is a form of liability insurance. Liability insurance indemnifies the insured against liabilities to third parties imposed by state (or federal) law. One of the liabilities imposed on private businesses, in their capacity as employers, is compensation for lost wages and medical treatment to employees who suffer occupationally-related injuries. 77 Pa. Stat. Ann. §§ 531(1), 717.1(a).

With certain limited exceptions, the Commonwealth of Pennsylvania and most other states require employers to financially secure the obligation to pay these benefits either by qualifying to self-insure or by purchasing workers' compensation insurance from a licensed insurer. 77 Pa. Stat. Ann. § 501(a)(1). Property and casualty insurers, however, are not required by the state to provide this type of insurance. Their decisions to enter or exit the workers' compensation insurance market are a matter of private business decision. Similarly, insurers have broad discretion in determining which employers they will underwrite, based on their independently-determined underwriting

standards and evaluation of risk. The relationship between insurer, insured employer, employee and medical care provider is thus a voluntary contractual one, albeit one extensively regulated by the state.[3]

Workers' compensation insurers, like most other types of regulated businesses, are subject to general statutory standards of conduct and agency oversight but, within these broad constraints, have wide discretion in making their business decisions. This case involves one such privately-determined choice.

Workers' compensation laws require the employer to provide medical treatment to workers for occupationally-related injuries but only for treatment that is "reasonable and necessary" for the employee's recovery and return to work. The medical component of workers' compensation thus is not tantamount to health insurance broadly providing coverage for all types of treatment but limits treatment in accordance with a return-to-work objective. Because workers' compensation insurance indemnifies employers only for this limited statutory obligation, the standard workers' compensation insurance policy used in Pennsylvania (as in most other states) reflects the statutory limitation of benefits to treatment that is "reasonable and necessary."

Prior to 1993, Pennsylvania, unlike most other states, significantly limited the insurer's remedies for enforcing the contractual limitation of benefits to "reasonable and necessary" treatment. Even if the insurer had grounds for believing the treatment to have been unnecessary or unreasonable, it was required to pay the provider after receipt of the bill. *See* R. VICTOR J. GARDNER, D. SWEENEY & C. TELLES, WORKERS' COMPENSATION RESEARCH INSTITUTE, COST DRIVERS IN SIX STATES 94 (1992). The

[3] *See* 7B JOHN A. APPLEMAN, INSURANCE LAW AND PRACTICE § 4624 ("[o]bligations assumed by a workers' compensation insurer are contractual in nature").

insurer's only remedy was to obtain an "Independent Medical Evaluation" ("IME") of the treatment by another provider and then, if the IME found the treatment to be unreasonable or unnecessary, to seek review of the treatment by a state administrative law judge. D. BALLANTYNE & C. TELLES, WORKERS' COMPENSATION RESEARCH INSTITUTE, WORKERS' COMPENSATION IN PENNSYLVANIA: ADMINISTRATIVE INVENTORY 58-71 (1991). But even if the insurer (or self-insured employer) prevailed, by law it could not recover the payment from the provider. *See Moats v. Workmen's Compensation Appeal Bd.*, 588 A.2d 116, 118 (Pa. Commw. Ct. 1991). The insurer's sole recourse was to obtain reimbursement from a special state "supersedeas" fund that was financed solely by assessments on the insurers and self-insureds themselves. BALLANTYNE & TELLES, *supra*, at xix, 38.

Not surprisingly, this "pay first, review later" system created a strong incentive for provider fraud and overtreatment—the provider was assured of payment notwithstanding the coverage limitations in the insurance policy. VICTOR, GARDNER, SWEENEY & TELLES, *supra*, at 94. In response, as one part of a package of comprehensive reforms, in 1993 the Pennsylvania legislature gave insurers a "self-help" remedy for enforcing the contractual coverage restriction that did not involve the active assistance of state officials. The insurer could elect to seek "utilization review" of questionable treatment by panels comprised of providers from the private sector. *See* 77 Pa. Stat. Ann. § 531(6). So that the utilization review decisions would be meaningful, the insurer was given the discretion—but was not required—to withhold payment of a provider's disputed bill pending the outcome of the review. *See id.* § 531(5); 34 Pa. Code § 127.208(e).

The issue presented in this case is whether this privately-initiated decision by the insurer to use a state-authorized, but private, remedy to enforce its contractual rights should be imputed to the state and thus subject to the Due Process Clause of the Fourteenth Amendment. Relying

heavily upon the regulated status of workers' compensation insurers, the Third Circuit held that insurer decisions to withhold payment of disputed bills pending utilization review was state action under all of the various tests elaborated by this Court. *Sullivan*, 139 F.3d at 170.

This decision should be reversed for one basic reason. Although Pennsylvania extensively regulates workers' compensation insurance, the insurer decisions challenged here —to withhold payment of disputed bills—were within the zone of business judgment left to the insurers by the regulatory scheme. The state thus cannot be deemed to be responsible for the private choice of the insurer and that decision is not subject to due process constraints.

II. NEITHER WORKERS' COMPENSATION INSURERS NOR SELF-INSURED EMPLOYERS PERFORM EXCLUSIVE OR EVEN TRADITIONAL STATE FUNCTIONS

One of the principal grounds upon which the Third Circuit based its finding of state action was the supposed exercise by workers' compensation insurers of powers that are "exclusively within the prerogative of the State." 139 F.3d at 170. In applying this "governmental function" standard, the lower court acknowledged that "insurance companies are private entities." *Id.* at 168. Nevertheless, it held that the insurers are "an arm of the State, fulfilling a uniquely governmental obligation under an entirely state-created, self-contained public benefit system." *Id.* This holding was based on a fundamental mischaracterization of workers' compensation laws—these statutes do not impose any payment obligation on the state itself and thus do not delegate to insurers any public function to administer a state obligation.

This Court first attributed the conduct of a private party to the state under a "public function" rationale in *Marsh v. Alabama*, 326 U.S. 501, 506-08 (1946), where a private business operating a "company town" performed

all of the necessary functions of a municipality. Subsequently, in *Jackson v. Metropolitan Edison Co.*, the Court clarified *Marsh*'s "public function" standard to require that a private actor must perform an *exclusive state function* before its conduct may be attributed to the state. 419 U.S. at 352-53.

Similar to the allegations in this case, the plaintiff in *Jackson* asserted that a utility's decision to terminate her service for nonpayment was state action because state utility statutes gave her an entitlement to "reasonably continuous service." *Id.* at 352. The Court rejected this argument because the "supplying of utility service is not traditionally the *exclusive* prerogative of the State." *Id.* at 353 (emphasis added). "[W]hile the Pennsylvania statute imposes an obligation to furnish service on regulated utilities, it imposes no such obligation on the State." *Id.* The Court warned that a broad reading of the "public function" test to include any industry subject to a governmental service mandate or to "public interest" regulation would impose constitutional constraints on all manner of private business:

> Doctors, optometrists, lawyers, Metropolitan [Edison], and [an] upstate New York grocery selling a quart of milk are all in regulated businesses, providing arguably essential goods and services, "affected with a public interest." We do not believe that such a status converts their every action, absent more, into that of the State.

Id. at 354 (footnote omitted). Since *Jackson*, this Court repeatedly has emphasized this exclusive state function requirement.[4]

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[4] *See Flagg Bros., Inc. v. Brooks*, 436 U.S. 149, 161 (1978) (a private party's proposed sale of garnished property under a state Uniform Commercial Code provision did not constitute state action because "the settlement of disputes between debtors and creditors

The obligation to pay workers' compensation benefits to injured workers has *never* been a traditional governmental function, let alone an exclusive one. As this Court recognized in *Dillard v. Industrial Comm'n of Va.*, 416 U.S. 783, 798 (1974), the funds used to pay workers' compensation benefits "are private, not public."

Prior to state adoption of workers' compensation laws in the early part of this century, the states had no responsibility for the payment of benefits to an injured employee. A worker's only recourse for injuries on the job was against the employer in tort. *See* L. FRIEDMAN, A HISTORY OF AMERICAN LAW 262-64, 411-14 (1973); *see also* ARTHUR LARSON, THE LAW OF WORKMEN'S COMPENSATION §§ 4.00-4.30 (1986); Richard Epstein, *The Historical Origins and Economic Structure of Workers' Compensation Law*, 16 GA. L. REV. 775 (1982).

The substitution of statutory remedies for common law ones under workers' compensation laws did not transfer to the state the obligation to compensate injured workers.[5] The statutes simply changed the legal standard governing an *employer's* pre-existing liability from one based on negligence to a no-fault one. Like the utility

is not traditionally an exclusive public function"); *Blum*, 457 U.S. at 1011 (nursing homes do not perform a traditional, exclusive state function); *Rendell-Baker v. Kohn*, 457 U.S. 830, 842 (1982) (provision of educational services, while "no doubt . . . is a public function," is not traditionally an *exclusive* public function); *San Francisco Arts & Athletics, Inc. v. United States Olympic Comm.*, 483 U.S. 522, 545 (1987) (regulation of amateur sports "had always been performed by private entities").

[5] Nor did the state become the insurer or guarantor of the private obligation. The Pennsylvania Workers' Compensation Security Fund referred to by the Third Circuit, 139 F.3d at 168 & n.18, protects employees against insurance company insolvency by guaranteeing the obligations of a bankrupt insurer. However, the Fund is financed exclusively through annual assessments on insurers themselves and thus Pennsylvania assumes no financial obligation even as insurer of last resort. 77 Pa. Stat. Ann. §§ 1053, 1055.

law in *Jackson*, the Pennsylvania workers' compensation statute imposes an obligation on private parties only; "it imposes no such obligation on the State." 419 U.S. at 353.

Thus, even accepting the Third Circuit's characterization of workers' compensation benefits as "constitutionally protected entitlement[s]," *Sullivan*, 139 F.3d at 168, that entitlement is not for *state-provided* benefits but rather for *privately-provided* ones. The payment of these benefits, therefore, does not represent the exercise of a government function but merely the satisfaction of a private party's financial obligation imposed by state law.[6]

The private nature of this obligation is not converted into a governmental obligation because of the exclusive remedy provision of the Pennsylvania workers' compensation law, relied upon so heavily by the Third Circuit. 139 F.3d at 168 (citing 77 Pa. Stat. Ann. § 481(a)). Whether the compensation remedy is one exclusively at common law (as formerly) or pursuant to statute (as now), the financial obligation to pay compensation falls upon the employer, not the state. The state merely prescribes the substantive law governing this private obligation, as it does in other types of tort or statutory schemes of compensation. The fact that state substantive law governs the rights and remedies of private employers in

[6] The lower court's analogy to *West v. Atkins*, 487 U.S. 42 (1988), is thus misplaced. In that case, the *state* itself had a constitutional obligation to provide medical care to prison inmates. *Id.* at 54 (citing *Estelle v. Gamble*, 429 U.S. 97, 104 (1976)). It delegated that responsibility to a physician who, under contract with the state, assumed responsibility for the performance of the state's constitutional duty. *Id.* at 55. Here, in contrast, Pennsylvania has no governmental obligation to pay benefits; it is "[t]he *employers* [who] are under an affirmative obligation to insure their employees for work-related accidents." *Sullivan*, 139 F.3d at 169 (emphasis added). The employer accordingly is not delegated any responsibility, by contract or by law, to act as an agent or contractor of the state in fulfilling a *state* obligation.

disputes with their employees does not confer a governmental function on those private parties. *See Flagg Bros.*, 436 U.S. at 160-61. The Third Circuit thus was mistaken in equating the "exclusivity" of the statutory remedy with the very different exclusivity requirement of the public function test.

Like employers, workers' compensation insurers do not perform a function that historically has been the exclusive prerogative of the State. Privately-owned property and casualty insurers underwriting coverage indemnifying insureds against liabilities were in existence long before the first workers' compensation laws were enacted. *See Paul v. Virginia*, 75 U.S. (8 Wall.) 168, 183 (1868) (discussing indemnity insurance contracts over 40 years before the first workers' compensation law was adopted in the United States). When those workers' compensation laws imposed the compensation obligation on employers, private insurers voluntarily elected to sell insurance covering those liabilities. This was not a function that the states traditionally had performed.

Indeed, insurers are not even subject to the state-imposed compensation mandate relied upon by the Third Circuit. Neither the Pennsylvania workers' compensation law nor the Commonwealth's insurance code require property and casualty insurers to underwrite workers' compensation coverage for employers. The decision to do so is entirely voluntary on the part of insurers.[7] Their coverage obligations thus arise as a result of private contracts, not a statutory mandate.

Nor does the state delegate to insurers (or self-insured employers) any traditional governmental responsibility for investigating and settling claims. State workers' com-

[7] *Cf.* 7B APPLEMAN, *supra*, § 4597 (insurers have choice of "whether to write the risk at all").

pensation agencies, such as the Pennsylvania Workers' Compensation Bureau, never have had this responsibility. Historically, the claims administration function has been performed by the claims department of the insurer or the human resources or benefits divisions of the employer.[8]

The Third Circuit was equally incorrect in characterizing the right to withhold payment to medical care providers as a "power that traditionally was held in the hands of the State." 139 F.3d at 168. Because the obligation to make such a payment never belonged to the state, the power to withhold payment was not a function ever exercised by the state. Historically, the insurer's right to refuse payment of a claim arose under the terms of the insurance contract itself.[9] That many states, including Pennsylvania, have chosen to regulate or limit this right does not transform it into a traditional or "exclusive prerogative of the state." *See Jackson*, 419 U.S. at 353.

In sum, the Third Circuit's expansionist interpretation of the "public function" standard should be rejected for the same reasons as in *Jackson*. The fact that the government imposes a regulatory mandate on a private party, whether a mandate to provide services or benefits (such as the payment of compensation) or a mandate to purchase (such as a requirement to purchase insurance or self-insure), does not represent the delegation of a gov-

[8] *See* 2 BUSINESS INSURANCE LAW AND GUIDE § 13.08[1] (1998) (when a worker is injured, "he is to give notice of the injury to his employer . . . so as to enable the employer to provide prompt medical diagnosis and treatment and to initiate an investigation of the facts surrounding the injury"). The state's role is limited to that of a neutral adjudicator at a later point in time, if and when a dispute over payment of compensation is brought before a state administrative law judge. *See* 77 Pa. Stat. Ann. § 531(6)(iv); 34 Pa. Code § 127.208(f).

[9] *See* 6B APPLEMAN, *supra*, § 4255 (an insurer is not liable if a claim "is clearly not within the scope of the policy's coverage").

ernmental duty when the state itself has never assumed that obligation.

III. REGULATED INSURERS ARE NOT AN "ARM" OF THE STATE BUT HAVE AN ARM'S LENGTH RELATIONSHIP WITH IT

Alternatively, the Third Circuit found the private insurer defendants to be state actors under the "joint participation" or "symbiotic relationship" standard first expressed in *Burton v. Wilmington Parking Auth.*, 365 U.S. 715 (1961). The appellate court held that the Pennsylvania workers' compensation law "inextricably entangles the insurance companies in a partnership with the Commonwealth such that they become an integral part of the state in administering a statutory scheme." 139 F.3d at 170. In so ruling, the court misconceived the principle underlying the "joint participation" test.

In order for private actors to be "joint participants" with the state, there must be some financial interdependency, state-granted assistance or similar mutually-beneficial relationship. In *Burton*, the Court found joint participation sufficient to constitute state action when a private restaurant owner and a municipal parking authority received mutual financial benefits from their relationship, including a tax exemption for the private party and increased revenue for the state arising out of restaurant profits earned as a result of the alleged racial discrimination. 365 U.S. at 723-24.

This Court repeatedly has rejected the notion that state regulation of private businesses, even extensive and pervasive regulation, creates this interdependency. "[P]rivately owned enterprises providing services that the State would not necessarily provide, even though they are extensively regulated, do not fall within the ambit of *Burton*['s]" joint participation standard. *Blum*, 457 U.S. at

1011.[10] Indeed, in *Blum*, the Court refused to find "joint participation" between a private nursing home and the state, even though the state paid for nursing home services under the Medicaid program and the challenged practices financially benefited the state by reducing Medicaid costs. 457 U.S. at 1005.

In this case, the relationship between the Commonwealth of Pennsylvania and private insurers or self-insured employers manifests none of the characteristics of financial interdependence or mutual benefits that satisfy the "joint participation" standard laid out by the Court. Unlike Social Security, Medicare and Medicaid, the state does not finance workers' compensation benefits through taxpayer funds or otherwise subsidize employers or insurers. The state does not have a proprietary relationship with insurers or employers like the governmental lessor in *Burton*. Nor does Pennsylvania share financial risk with insurers even to the extent of the Medicaid cost reduction found insufficient to support joint participation in *Blum*.

Moreover, contrary to the lower court's characterization of the regulatory scheme, Pennsylvania has not delegated any administrative power to insurers. Insurers investigate claims and suspend payments for disputed claims, not because the state has delegated to them this authority, but because they have financial interests and rights independently arising from their contracts of insurance. The administration of the state's regulatory scheme is performed exclusively by state officials, and insurers are bound by any regulations promulgated by the state. The relationship is an arm's-length one between the regulated insurer or employer and state regulators who are required to be independent of those they regulate.

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[10] *See also Jackson*, 419 U.S. at 350, 358; *Rendell-Baker*, 457 U.S. at 841; *Moose Lodge No. 107 v. Irvis*, 407 U.S. 163, 176-77 (1972).

IV. PENNSYLVANIA DID NOT COMPEL OR ACTIVELY ENCOURAGE THE INSURER DECISIONS BUT MERELY ACQUIESCED IN THEM

Contrary to this Court's focus in state action cases involving private parties, the Third Circuit's emphasis was on Pennsylvania's general scheme of regulation, irrespective of whether the specific private conduct at issue—the withholding of claims payments—was directly subject to a regulatory mandate or directive. *See Rendell-Baker*, 457 U.S. at 841. The lower court did find, however, what it characterized as state approval of the insurer's decision to suspend payment of provider bills "because an insurer cannot suspend medical payments without first obtaining authorization from the Bureau." 139 F.3d at 168. The court thus concluded that the challenged insurer activities satisfied this Court's "active encouragement" test for finding state action. *Id.* at 170.

In fact, Pennsylvania's involvement is limited to (1) a statute affording insurers the option of withholding payment but without requiring them to obtain case-by-case state approval in order to do so and (2) a regulation requiring an after-the-fact notice filing with the Bureau which is reviewed solely for conformance with procedural filing requirements. This generic statutory authorization of an elective private remedy and passive acquiescence in the insurer's decision to use that remedy falls far short of the state compulsion, coercion, enforcement or "active assistance" necessary to attribute the conduct of regulated parties to the state.

On its face, the Pennsylvania utilization review statute does not *demand* that an insurer request such review nor does it *require* the insurer to withhold payment of bills if it makes such a request. Rather, the statute and its implementing regulations are permissive: "The 30-day period in which payment shall be made to the provider *may* be tolled only if review of the reasonableness or necessity of

the treatment is requested." 34 Pa. Code § 127.208(e) (emphasis added). Thus, an insurer, acting entirely under its own volition, may choose to dispute the reasonableness of treatment and additionally elect to withhold payment pending resolution of the dispute. The lower court in fact acknowledged the permissive nature of the statute. 139 F.3d at 164 ("The Act does not require—but permits—suspension of medical benefits.").

Further, what the Third Circuit characterized as "authorization" by the Bureau amounts to nothing more than a bureaucratic rubberstamp after the insurer files a request for utilization review:

> The Bureau reviews the Initial Request to ensure that it is properly completed—*i.e.*, that all information required by the form is provided. *See* 34 Pa. Code § 127.452. The Bureau's review of the Initial Request does not address the legitimacy or lack thereof of the request for utilization review.

Id. at 163. This notice filing, moreover, is made only *after* the insurer already has made the decision to suspend payment pending utilization review. The state thus undertakes no review whatsoever—even a clerical review—of that decision. Pennsylvania's *de minimis* involvement in the insurer's decision does not even come close to constituting "active state encouragement" under this Court's standard.

The "active encouragement" decisions of this Court focus on the degree of choice permitted a private actor under state law. Thus, a regulated company's "exercise of the choice allowed by state law where the initiative comes from it and not from the State, does not make its actions in doing so 'state action' for purposes of the Fourteenth Amendment." *Jackson*, 419 U.S. at 357 (footnote omitted). In the few cases where this Court has found state action under the "active encouragement" standard, the State has had a substantial role in controlling the pri-

vate decision by coercing, compelling or enforcing it. *See Peterson v. Greenville*, 373 U.S. 244, 247-48 (1963) (city ordinance required private restaurant owner to segregate on basis of race); *Shelley v. Kraemer*, 334 U.S. 1 (1948) (racially restrictive covenant enforced by state courts); *Edmonson v. Leesville Concrete Co.*, 500 U.S. 614, 627-28 (1991) (state courts enforced race-based peremptory challenges). But "[t]his Court . . . has never held that a State's *mere acquiescence* in a private action converts that action into that of the State." *Flagg Bros.*, 436 U.S. at 164 (emphasis added).

The limited scope of the "active encouragement" test was expressly recognized in *Blum*, where the Court held that "a State normally can be held responsible for a private decision only when it has *exercised coercive power* or has provided such *significant encouragement*, either overt or covert, that the choice must in law be deemed to be that of the State." 457 U.S. at 1004 (emphasis added). There, plaintiffs challenged under the Due Process Clause a private nursing home's decision to transfer Medicaid patients. Applicable New York regulations authorized nursing homes to make patient transfer decisions and spelled out the general criteria for making those decisions. *Id.* at 1006. The regulations required nursing homes to use utilization review in making transfer decisions and they were subject to sanctions for failing to do so. *Id.* at 994-95. Nevertheless, those regulations were insufficient to attribute the nursing home decisions to the state because the decisions "ultimately turn on medical judgments made by private parties according to professional standards that are not established by the State." *Id.* at 1008.

In two respects, the Pennsylvania statute at issue here affords insurers greater discretion than the New York regulations gave nursing homes and thus surely cannot be considered to have directed or controlled insurer decisions.

First, the Pennsylvania utilization review provision is permissive, unlike the mandatory New York provision. Second, unlike the New York regulations, the Pennsylvania statute sets forth no substantive criteria whatsoever governing the insurer's right to suspend payment of provider bills.

At most, the Pennsylvania statute only authorizes insurers to use a "self-help" measure to protect their financial interests without the need to institute any state proceeding or obtain the active assistance of any state official. There is no state action because the state "has merely announced the circumstances under which it[] . . . will not interfere with a private" remedy. *See Flagg Bros.*, 346 U.S. at 166. Put differently, the insurer's use of a "self-executing" statute which tolls the time for payment, like a statute of limitations, does not implicate the state in a private action. *See id.* at 166; *see also Texaco, Inc. v. Short*, 454 U.S. 516 (1982).[11]

Nor does the Bureau's filing requirement convert the insurer's discretionary action into state action. Indeed, in *Blum*, the Court rejected the very same argument embraced by the Third Circuit here—that a notice filing with the state transforms private conduct into state action. The State of New York required a nursing home physician to complete a "long term care placement form" devised by the state to assess whether each patient's care

[11] The Third Circuit mistakenly relied upon *Tulsa Prof'l Collection Servs., Inc. v. Pope*, 485 U.S. 478 (1988), in finding that the Pennsylvania statute was not self-executing. In *Pope*, the challenged notice provision became "operative only after probate proceedings have been commenced in state court," and the court has appointed an executor. *Id.* at 487. The probate court there was "intimately involved throughout." *Id.* Here, by contrast, there is no state court or administrative proceeding commenced at the time when the insurer withholds payment of the provider bill. The first state proceedings do not occur until far down the road, after the completion of utilization review and an election by an aggrieved party to appeal that decision to an administrative law judge.

remained "medically necessary." *Id.* at 1006. The Court reasoned that the filing of the form did not convert the private decision of the physician into state action: "[T]he physicians, and not the forms, make the decision about whether the patient's care is medically necessary . . . . *We cannot say that the State, by requiring completion of a form, is responsible for the physician's decision.*" *Id.* at 1006-07 (emphasis added).

Even if Pennsylvania had required the insurer to secure advance Bureau approval of a decision to suspend payment, the insurer decision still could not be attributed to the state. In *Jackson,* electric utilities could terminate service to customers only if they first filed a tariff with state regulators proposing criteria and procedures for termination. The applicable regulatory statute required regulators to substantively review the filing and it went into effect if the regulators found no grounds to disapprove it. The Court refused to attribute the utility's service termination decision to the regulators' approval of the filing because the decision was initiated by the utility and was only acquiesced in, not encouraged, by the regulator:

> The nature of governmental regulation of private utilities is such that a utility may frequently be required by the state regulatory scheme to obtain approval for practices a business regulated in less detail would be free to institute without any approval from a regulatory body. Approval by a state utility commission of such a request from a regulated utility, where the commission has not put its own weight on the side of the proposed practice by ordering it, does not transmute a practice initiated by the utility and approved by the commission into "state action." . . . Respondent's exercise of the choice allowed by state law where the initiative comes from it and not from the State, does not make its action in doing so "state action" for purposes of the Fourteenth Amendment.

419 U.S. at 357. Similarly here, the insurer's determination to suspend payment of disputed bills was the product of its own initiative, not any state compulsion or state policy actively encouraging that decision.[12]

V. THE THIRD CIRCUIT'S STATE ACTION HOLDING WILL INVITE PREEMPTION OF STATE REGULATION AND FEDERAL JUDICIAL REGULATION OF PRIVATE BUSINESSES

At bottom, the Third Circuit's conclusion that the insurers' nonpayment decisions were state action is based entirely on the mere existence of a general scheme for regulating workers' compensation insurance but one which did not compel, actively encourage or enforce the specific insurer decisions in question. This expansionist notion of state action should be rejected, as it has been in prior decisions of this Court, because it would result in wholesale transformation of many private but regulated businesses into state actors subject to direct federal regulation. The lower court's approach, moreover, is a recipe for

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[12] Should the Court overrule the decision below for these reasons, it should additionally overrule the decision of the three-judge panel in *Baksalary v. Smith,* 579 F. Supp. 218 (E.D. Pa. 1984), which was relied upon by the Third Circuit in *Sullivan* and which was based on the same rationale. As in this case, the Pennsylvania statutory provision at issue in *Baksalary* authorized workers' compensation insurers to suspend payment of disability (rather than medical treatment) benefits pending final resolution of a dispute over the employee's eligibility to continue receiving them. As here, the insurer was required to "file a petition on a form provided by the [Bureau of Workers' Compensation]", as well as a physician affidavit attesting to the worker's recovery. 579 F. Supp. at 231. As here, the Bureau's review of the petition was purely procedural: "Although the Bureau does not review the petition's merits, it does review the petition for formal compliance with the Workmen's Compensation Act." *Id.* Because *Baksalary* found "active state encouragement" resting on the same permissive type of statute and simple notice filing relied upon in *Sullivan,* it is flawed in the same respects as the decision under review here.

massive preemption of state regulation under the guise of constitutional doctrine.

The Third Circuit ultimately based its finding of state action on three characteristics of Pennsylvania's "comprehensive statutory scheme" for regulating workers' compensation insurance: (1) the "entitlement" created by the compensation mandate imposed on employers; (2) the "essential" nature of workers' compensation insurance because of the requirement that employers fund benefits by insurance or self-insurance; and (3) the "exclusivity" of the remedy afforded employees under the workers' compensation law. None of these attributes are unique to regulation of workers' compensation insurance but are common to many state insurance regulatory schemes.

Many states impose coverage obligations on private parties that can be characterized as a "guarantee" or "entitlement" by the state in the same way that the Third Circuit characterized workers' compensation benefits—not in the sense that they are financial obligations of the state, but only in the sense that state law imposes the obligation or creates the right. For example, many states mandate the types of health insurance benefits that employers must afford to their employees.[13]

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[13] *See, e.g.*, Mass. Stat. ch. 175, § 47B; Ill. Stat. ch. 215 § 5/367(7); Ariz. Rev. Stat. § 20-1402(4); Conn. Stat. § 38a-514. *See also Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 727-30 (1985) ("General health insurance typically is sold as group insurance to an employer or other group. Group insurance . . . is subject to extensive state regulation, including regulation of . . . the content of the contracts. . . . Different states mandate a great variety of different kinds of insurance coverage. For example, many require alcoholism coverage, . . . while others require certain birth-defect coverage, . . . outpatient kidney-dialysis coverage, . . . or reconstructive surgery for insured mastectomies.") (citations and footnote omitted). *See generally* EMPLOYEE BENEFITS RESEARCH INSTITUTE, DATABOOK ON EMPLOYEE BENEFITS 269-70 (4th ed. 1997) (listing the "975 different health care mandates in force in the 50 states and the District of Columbia").

Many states also impose insurance purchasing or self-insurance requirements similar to workers' compensation laws. Automobile drivers in all fifty states are required to purchase liability coverage to protect third parties or otherwise to demonstrate financial responsibility before operating a motor vehicle.[14] Some states require companies engaged in the business of remediating pollution from underground storage tanks to provide evidence of financial responsibility, which may be in the form of insurance or self-insurance.[15]

Finally, many state insurance regulatory schemes displace common law remedies and make the statutory remedy exclusive. Many states, for instance, have enacted no-fault automobile insurance laws that displace traditional tort remedies.[16]

These various state insurance laws create third-party "entitlements" or make insurance "essential" or make statutory remedies "exclusive" no less than Pennsylvania's workers' compensation law. Yet, like workers' compensation statutes, these insurance regulatory schemes reserve to insurers a large zone of freedom where decisions are a matter of business judgment subject only to requirements that state regulators receive notice of those decisions (*e.g.*, filings of proposed rates and policy forms) and retain the

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[14] *See, e.g.*, Ariz. Rev. Stat. §§ 4009, 28-4135; Cal. Veh. Code §§ 16020-16021; Ill. Comp. Stat. § 5/7-601; Mass. Ann. Laws ch. 90, §§ 34A-34B; N.H. Rev. Stat. Ann. § 264:3; N.Y. Veh. & Traf. Law § 312.

[15] *See, e.g.*, 35 Pa. Stat. Ann. § 6021.701; N.J. Stat. Ann. §§ 58:10A-24.3, 58:10A-24.4(b).

[16] *See, e.g.*, Col. Rev. Stat. §§ 10-4-701 *et seq.*; Fla. Stat. Ann. §§ 627.730-627.7405; Haw. Rev. Stat. §§ 431:10C-101 *et seq.*; Ky. Rev. Stat. Ann. §§ 304.39-010 *et seq.*; Mass Ann. Laws ch. 90, § 34M; Mich. Stat. Ann. §§ 24.13101 *et seq.*; Minn. Stat. §§ 65B.41 *et seq.*; N.J. Stat. Ann. § 39:6A-4; N.Y. Ins. Laws §§ 5101 *et seq.*; N.D. Cent. Code §§ 26.1-41-01 *et seq.*; 75 Pa. Cons. Stat. §§ 1701 *et seq.*; Utah Code Ann. §§ 31A-22-301 *et seq.*

power to intervene. Further, none of these insurance regulatory statutes delegates to the insurer the power to exercise any regulatory or administrative function on behalf of the state. Under these permissive schemes of regulation, the role of the insurer is not as an agent, "arm" or "appendage" of the state as the Third Circuit viewed it. The insurer does not *act* as regulator but is *subject* to regulation.

Under the Third Circuit's expansive state action tests, however, the discretionary business judgments of private insurers would be subject to the full panoply of constitutional constraints across the entire spectrum of their business activities. The mere fact that the state imposes a liability, or that a policyholder is required to buy insurance, or that the insured's statutory remedies are exclusive, would make the regulated insurer an "arm" of the state in administering an "exclusive" system of "public benefits." Private insurance contracts would become a state entitlement requiring the insurer to treat claimants as if they were beneficiaries of public funds. A wide variety of insurer functions would thereby become subject to constitutional regulation including, for example, underwriting decisions (because they affect the ultimate availability of the "entitlement") and coverage or claims decisions (because they immediately affect the availability of the "entitlement").

Insurers would be placed in the dilemma of either paying claims that they believe exceed their contractual obligations, in order to avoid liability for damages under 42 U.S.C. § 1983, or providing formal hearing rights of the type required in judicial proceedings, in order to contest the claim. The entire process by which claims are investigated, negotiated and settled—usually well short of administrative procedings or litigation—would become unnecessarily cumbersome, adversarial and costly. Underwriting and claims activities would become subject to due process constraints irrespective of whether a state law eliminated insurer discretion or whether the insurer

had the active assistance of any state official in implementing or enforcing its decision. In addition, insurers would become subject to equal protection constraints directly colliding with one of their primary business functions—discriminating between risks on the basis of actuarial differences.

The Third Circuit's expansionist state action tests not only would usurp insurer contractual rights but threaten state regulatory power in the area of insurance claims disputes. State claims regulation would become subject to constitutional preemption notwithstanding the state's decision to encourage the private resolution of claims disputes. Even if the insurer claims practices in question are discretionary and privately-initiated ones, the state would become responsible for the private action and its regulatory scheme subject to collateral attack.

The likely consequences of the Third Circuit's approach —increased preemption of state law and federal judicial regulation of private insurance transactions—is fundamentally in conflict with the purpose of 42 U.S.C. § 1983 and the Fourteenth Amendment. The objective of both is to protect private persons from the arbitrary actions of state officials and agencies, not to expand federal authority to regulate those persons directly through a "court-made scheme of federal constitutional regulation." William M. Burke & David J. Reber, *State Action, Constitutional Power and Creditors' Rights: An Essay on the Fourteenth Amendment*, 46 S. CAL. L. REV. 103, 193 (1973); *see also* Henry C. Strickland, *The State Action Doctrine in the Rehnquist Court*, 18 HASTINGS CONST. L. Q. 587, 595 (1991).

The state action requirement implements this limitation by preventing federal courts from regulating the conduct of private entities that the Constitution reserves to the states: "By limiting the [Fourteenth] Amendment's application to state governmental actors, . . . the state action requirement prevents federal courts from using the Amend-

ment to regulate private activity that the Constitution reserved for state—not federal—authority." Strickland, *supra*, at 595-96. The state action requirement "also prevents the federal courts from using the Fourteenth Amendment to usurp authority that the Constitution granted to the executive and legislative branches. . . . By limiting the application of the Fourteenth Amendment to governments, the state action requirement prevents federal courts from directly regulating private activity that the Constitution deemed best governed by the representative branches." *Id.* at 596 (footnote omitted).

The Third Circuit's treatment of regulated insurers as "partners" of the state fundamentally subverts these principles by transforming the Fourteenth Amendment and Section 1983 from shields against arbitrary government actions into vehicles for increased federal judicial regulation of private insurance transactions. This new layer of federal regulation of the insurer-policyholder relationship would be imposed notwithstanding Congress' decision, in the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1015, to defer to state regulation of the "business of insurance"—the heart of which has been defined as the relationship between the insurer and insured. *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 215-17 (1979); *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 128-29 (1982). Indeed, this Court specifically has held that the performance of the insurer's obligations under the contract of insurance—the very matter at issue here—is exclusively subject to state regulation. *United States Dep't of the Treasury v. Fabe*, 508 U.S. 491 (1993). The Third Circuit's state action finding ultimately should be rejected because it is an open invitation to the lower federal courts to regulate claims disputes between insurers and insureds based on policy judgments contrary to those made by the state regulators to whom deference is constitutionally and statutorily due.

This case provides a perfect illustration of how a decision nominally applying the Due Process Clause to the

conduct of regulated insurers is really secondguessing of state regulatory policy. In effect, the Third Circuit made a policy judgment that a patient's or provider's right to prompt payment of medical bills trumped the public interest in combating provider fraud and containing the cost of medical care. This judgment, however, is squarely at odds with the judgment of the Pennsylvania legislature.

Prior to 1993, workers' compensation markets in Pennsylvania and many other states suffered turmoil as medical care costs associated with workers' compensation accelerated steeply, at rates far greater than health care costs generally.[17] A major cause of these exploding medical expenses were the incentives under the workers' compensation law for providers to overbill and overtreat. There were few limits placed under the Pennsylvania system on the selection of providers and on the treatment given by those providers. Of particular relevance here, while an employer or insurer could challenge a provider's treatment as unnecessary or unreasonable, that provider would continue to receive payment pending the resolution of the challenge and was not required to disgorge the payment even if the treatment ultimately was determined to be unnecesary or unreasonable.[18]

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[17] *See* BALLANTYNE & TELLES, *supra*, at 30 (discussing "spiraling costs of medical treatment for work-related injuries" as a "significant problem[] in the Pennsylvania system"). *See also* S. ECCLESTON & C. YEAGER, WORKERS' COMPENSATION RESEARCH INSTITUTE, MANAGED CARE AND MEDICAL COST CONTAINMENT IN WORKERS' COMPENSATION, A NATIONAL INVENTORY, 1997-1998, at 4 (1997) (from 1985 to 1992, aggregate national medical expenditures for workers' compensation rose 157 percent, compared to a 94 percent rise in national health care costs overall); Emily Spieler, *Perpetuating Risk?*, 31 HOUS. L. REV. 119, 135 (1994) (in a 1991 "industry survey, seventy percent of employers reported that workers' compensation costs were threatening their financial results") (footnote omitted).

[18] *See* VICTOR, GARDNER, SWEENEY & TELLES, *supra*, at 94. *See also* BALLANTYNE & TELLES, *supra*, at xxi (as of 1991, "Pennsylvania employ[ed] few of the cost containment strategies common to other states . . . .").

As noted, in 1993, the Pennsylvania legislature acted to eliminate this incentive for overtreatment by permitting insurers and self-insured employers to forebear payment of health care provider bills pending utilization review of the reasonableness or necessity of the treatment given. *See* 77 Pa. Stat. Ann. § 531(5); 34 Pa. Code § 127.208. The 1993 reforms in general and the utilization review system in particular proved effective. "The most notable system improvement was a sharp drop in medical benefit costs from 1993 to 1995," attributable in large part to the "medical cost controls instituted by the 1993 amendments." D. BALLANTYNE, WORKERS' COMPENSATION RESEARCH INSTITUTE, REVISITING WORKERS' COMPENSATION IN PENNSYLVANIA: ADMINISTRATIVE INVENTORY at xi (1997).

In over two-thirds of the cases submitted for utilization review, all or some of the medical treatment was found to be unnecessary or unreasonable. Letter from Timothy Wisecarver, President, Pennsylvania Compensation Rating Bureau, to Richard Himler, Director, Pennsylvania Bureau of Workers' Compensation (July 1, 1998) (reproduced in the Appendix to the Brief of *Amici Curiae* American Insurance Association, *et al.*, in Support of the Petition). By detecting this overtreatment, the utilization review system produced approximately $32 million in direct annual savings. Letter from Timothy Wisecarver, President, Pennsylvania Compensation Rating Bureau, to Richard Himler, Director, Pennsylvania Bureau of Workers' Compensation (October 29, 1998) (reproduced in the Appendix to this brief).

The Third Circuit's decision, however, threatens to render utilization review meaningless as a mechanism to prevent unreasonable and unnecessary treatment. By striking down that part of the statute that allows insurers to delay payment pending utilization review, the court has recreated a system under which insurers must "pay first, review later." Thus, despite the nominal existence of a "review" system, providers will again have an incentive to bill for improper treatment because they know that they will receive payment promptly, irrespective of whether the treatment provided was reasonable and necessary, and that they will not be required to disgorge payment irrespective of the outcome of the "review." The Third Circuit's ruling resurrects a system fostering provider fraud and abuse and frustrating the purpose of the 1993 cost containment reforms. Indeed, the lower court's decision already has had a chilling effect on utilization review, which has declined 60 percent. *See* Appendix.

In addition, the decision below would require insurers and private utilization review panels to adopt quasi-adjudicative procedures for handling claims disputes that could impose significant new costs. More importantly, and ironically, the lower court's decision creates a huge loophole in Pennsylvania's exclusive remedy provision so heavily emphasized by the Third Circuit. Unlike governmental entities, if private insurers are treated as state actors, they may not have sovereign immunity from damages claims asserted under 42 U.S.C. § 1983. The award of such damages would obviously be inconsistent with the exclusive remedy limitation in the Pennsylvania law by allowing an employee to recover a greater amount than permitted under the policy and under the statutory limitations on benefits.

As a result, the decision below is likely to lead to a significant increase in insurance claims costs as insurers pay for unreasonable or unnecessary treatment or for Section 1983 damages going beyond their policy obligations. Although insurers and self-insured employers may recover from a "supersedeas" fund for excessive payments made to medical care providers, 34 Pa. Code § 127.208 (g), that fund is financed by assessments on them. Therefore, insurers and self-insured employers essentially bear the entire cost of the unreasonable and unnecessary treatments. As that cost increases, insurers may either increase their rates or decide not to cover the risk, decreasing insurance availability and potentially recreating the pre-

1993 crisis in the Pennsylvania workers' compensation market.[19] Such constrictions on insurance availability and affordability make insurance less efficient as a means of spreading and minimizing the costs of the workers' compensation, adversely affecting benefits, employment and wages.

In sum, although intended to advance the procedural rights of injured workers, the Third Circuit's ruling may ultimately harm the basic economic intersts of those very workers. This is precisely why, under our constitutional framework, judgments about economic and social regulatory policy are reserved to the states and the representative branches of the federal government.

CONCLUSION

For the reasons stated herein, the judgment of the United States Court of Appeals for the Third Circuit should be reversed.

Respectfully submitted,

MARK F. HORNING
Counsel of Record
SHANNEN W. COFFIN
GWENDOLYN PROTHRO
STEPTOE & JOHNSON LLP
1330 Connecticut Avenue, N.W.
Washington, D.C. 20036
(202) 429-8126
Counsel for Amici Curiae

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[19] *See* Floor Statement of Rep. Fargo, Pa. House Journal at 547 (Mar. 30, 1993) (noting need for reform and cost containment measures, because "insurance companies, an awful lot of them in Pennsylvania, are refusing to write workers' compensation"); *see also SMC/Pennsylvania Small Business: Small Business Hurt Most by Delay in Reform of Workers' Compensation Crisis*, PR Newswire (June 1, 1992) (small business owner lamented: "We've had an average increase in our insurance rates of 35 percent a year. . . . My insurance agent tells me that it's getting harder and harder to find any companies that will sell me workers' compensation insurance").

APPENDIX

APPENDIX [1]

[PCRB Logo]

PENNSYLVANIA COMPENSATION
RATING BUREAU
The Widener Building • 6th Floor
One South Penn Square
Philadelphia, PA 19107-3577
(215) 568-2371 • FAX (215) 564-4328

October 29, 1998

VIA FACSIMILE & FIRST CLASS MAIL

Mr. Richard Himler
Director
Pennsylvania Bureau of Workers' Compensation
Department of Labor & Industry
Commonwealth of Pennsylvania
1171 South Cameron Street, Room 103
Harrisburg, PA 17104-2501

RE: Utilization Review Experience Under Pennsylvania's Workers Compensation Act

Dear Mr. Himler:

This letter revises and supersedes my correspondence of October 28, 1998 and supplements my correspondence of July 1, 1998 concerning analysis which the Pennsylvania Compensation Rating Bureau (PCRB) continues to perform with respect to the utilization review processes in Pennsylvania in the context of the Sullivan decison. In particular, this letter will update you concerning our work to date in attempting to quantify the historical dollar impact of utilization review on workers compensation costs in Pennsylvania.

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[1] A copy of this letter was lodged with the Office of the Clerk of the Supreme Court on the date of filing of this brief.

The PCRB's interest in this matter derives from our responsibilities as the licensed rating organization for workers compensation insurance other than coal mine exposures in Pennsylvania. We are sharing the results of our work with you, recognizing the key role which the Department of Labor and Industry, Bureau of Workers' Compensation (BWC) plays in the effective and equitable administration of many provisions of the Pennsylvania Workers Compensation Act, and as a nominal means of reciprocating for the many courtesies which your office has previously extended to us in sharing information and insights pertaining to the Pennsylvania workers compensation system.

Based on the data previously provided by your agency, the PCRB has been able to identify the predominant types of medical providers historically involved in utilization review requests in Pennsylvania. Of some 25,265 such requests with identified provider types, approximately 37 percent were for chiropractors, 17 percent for family doctors or general practitioners, nine percent for physical therapists and six percent for othopedic doctors.

The PCRB has attempted to complement the comprehensive information related to the incidence and disposition of utilization review requests previously provided to us by your office with details concerning the dollar value of medical services addressed by utilization review requests. As identification of such dollar values is an inherently labor intensive process requiring access to individual claim file documentation, the PCRB has sought this additional data by asking selected carrier members to review their own claims for which utilization review requests were previously made on a sampling basis. The PCRB has discussed the information provided in response to these requests with each of the carriers which have given us information in order to enhance our understanding of the form and content thereof. We have relied on the accuracy of the individual claim detail submitted to us without independent verification.

As of this writing, the PCRB has received and reviewed claim detail information from four separate carriers. In total some 363 claims have been thus reviewed and reported to the PCRB. This currently available data is limited, and the PCRB continues to attempt to obtain additional information from a broader complement of insurers. However, our analysis of this preliminary information has produced substantive indications that the utilization review process in Pennsylvania prior to the Sullivan decision had resulted in significant savings of medical costs through the identification of unreasonable and/or unnecessary medical treatment.

The following is a synopsis of key results of our analysis and their implications for the probable effects of utilization review pre-Sullivan on the prevailing and continuing cost of Pennsylvania workers compensation claims.

- Based on the sample of 363 claims reviewed to date, the PCRB estimates the net direct savings attributable to utilization review before the Sullivan decisions at approximately $32 million per year. These savings are "net" in the sense that they recognize the costs of reimbursing the Utilization Review Organizations (UROs) for their services related to the adjudication of utilization review requests and have also been adjusted for incidental litigation expenses such as costs for expert witnesses and attorneys' fees. These savings are "direct" in that they are limited strictly to the population of claims for which utilization review requests were actually filed on an annual basis since the inception of the utilization review process in late 1993.
- A substantial majority of the above referenced estimated net direct savings are attributable to the cessation or modification of proposed medical services *after* the rendering of utilization review decisions. In other words, the *prospective* changes in authorized medical procedures are responsible for significantly more of the

observed direct effects of utilization review determinations on medical costs rather than is the denial of payment for *previously rendered or recommended* services.

- The *indirect* effects of utilization review decisions on medical costs are potentially much greater than the *direct* effects of these decisions. (By "indirect" effects we are referring to influences on medical treatments recommended or performed on claims for which utilization review requests have *not* been filed but which present similar circumstances to other claims in which utilization review requests *have* been filed and determinations have been rendered that certain types of treatment are not reasonable or necessary.) This is the case because many more claims may be affected by such precedents than are required to establish them. A given provider may change their approach(es) to treatment of certain conditions based on a relatively small number of personal and/or anecdotal experiences in the utilization review process, but those changes once made will often apply to a much greater number of similar future cases.
- To the extent that there is *any* indirect effect of utilization review decisions on medical costs for workers compensation claims, estimates of the effects of this process on costs which are limited to evaluations of cases for which utilization review requests were actually filed will be somewhat understated. Because the PCRB believes, based on all available information, that the indirect effects of utilization review findings in Pennsylvania have likely been quite significant, we are also of the opinion that the actual effect of this process pre-Sullivan was substantially greater than the estimate of $32 million per year noted above.
- Finally, the PCRB understands that, since the issuance of the Sullivan decision, the numbers of utilization review petitions being presented to the Department of

Labor & Industry, Bureau of Workers Compensation (BWC) and subsequently assigned to UROs for action has declined markedly. For example, your office has informed us that for the six months ending December 31, 1997 a total of 3,569 utilization review requests were assigned by the BWC. The Sullivan decision was rendered in March 1998. For the six months ending September 30, 1998 a total of only 1,478 utilization review requests were assigned by the BWC, a decline of almost 60 percent from pre-Sullivan levels. This suggests that in the near term the Sullivan decision materially reduced the use of utilization review processes as a means of monitoring and controlling medical costs associated with unreasonable and/or unnecessary treatment in Pennsylvania.

The PCRB will continue to assimilate additional claim detail data into our estimates if and when that information is received and will keep your office apprised of the results of that continuing effort as they become available. Should you have any questions or comments in regard to this ongoing evaluation, I am available at your request to respond to them.

Sincerely,

/s/ Timothy L. Wisecarver
TIMOTHY L. WISECARVER
President

TLW/kg

(9)

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IN THE
Supreme Court of the United States
October Term, 1998

AMERICAN MANUFACTURERS MUTUAL INSURANCE COMPANY, et al.,
Petitioners,

v.

DELORES SCOTT SULLIVAN, et al.,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Third Circuit

BRIEF AMICUS CURIAE OF THE WASHINGTON LEGAL FOUNDATION IN SUPPORT OF PETITIONERS

Daniel J. Popeo
Paul D. Kamenar
WASHINGTON LEGAL FOUNDATION
2009 Massachusetts Ave., N.W.
Washington, D.C. 20036
(202) 588-0302

Ronald D. Maines
Counsel of Record
MAINES & LOEB, PLLC
1827 Jefferson Place, N.W.
Washington, D.C. 20036
(202) 223-2817

Date: November 10, 1998

CASILLAS PRESS 1717 K STREET, N.W. WASHINGTON, D.C. 20006 (202) 223-1220

2488

QUESTIONS PRESENTED

Under Pennsylvania's Workers' Compensation Act, 77 Pa. Stat. Ann. § 531(5) and (6), workers' compensation insurers are permitted to withhold payments to health care providers during a utilization review to determine whether medical treatment was reasonable and necessary. The questions presented are:

I. Whether private companies providing workers' compensation insurance to private employers become "state actors" for purposes of the Due Process Clause when they elect to use a state-authorized utilization review procedure.

II. Whether the Due Process Clause requires workers' compensation insurers to pay disputed medical bills prior to a determination that the medical treatment was reasonable and necessary.

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INTEREST OF AMICUS CURIAE

Washington Legal Foundation (WLF) is a national, nonprofit, public interest and policy center based in Washington, D.C., with supporters nationwide. WLF devotes substantial resources to litigating cases and publishing educational materials that promote limited and accountable government, the proper role of the judiciary, reasonable government regulation, and due process protection for businesses. WLF has regularly appeared before this Court as amicus curiae advocating these principles. *See, e.g., Lujan v. Defenders of Wildlife*, 504 U.S. 555 (1992); *Steel Company v. Citizens for a Better Environment*, 118 S.Ct. 1003 (1998); *BMW of North America, Inc. v. Gore*, 517 U.S. 559 (1996); *Eastern Enterprises v. Apfel*, 118 S.Ct. 2131 (1998). WLF is concerned that if the lower court judgment in the instant case is upheld, the imposition of "state actor" status on otherwise private regulated businesses for purposes of the Due Process Clause could have a far-reaching impact on other heavily regulated industries such as health care providers, banks, telecommunication carriers, and the like. Our brief thus focuses on Issue One of the questions presented.[1]

SUMMARY OF ARGUMENT

In his classic work THE SOPHIST — Plato analyzes the theoretical conditions that ensure the validity of judicial decisionmaking. THE SOPHIST (Plato) (J. Turrell tr., 1961). In particular, Plato explores the conceptual errors at work

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[1] Pursuant to Supreme Court Rule 37.6, WLF states that no counsel for a party authored this brief in whole or in part; and that no person or entity, other than amicus and its counsel, contributed monetarily to the preparation and submission of this brief. Written general consents to the filing of this and other amicus briefs in this proceeding have been lodged with the Clerk.

whenever the task of delineating a legal concept goes awry. Because the process requires the ability to "distinguish according to real distinctions," mistakes most commonly result from "faulty generalizations" and the failure to discern the "essential affinities" between related rules of law. A lapse in the rigor of the analysis — which makes the result resemble the work of "an inefficient butcher" — will be ruinous to the public weal. To avoid that outcome, careful attention to the "natural joints" of the matter — its genuine logical and definitional contours — is crucial. *Id.* at 97-99.

Courts required to decide when private action becomes state action for the purposes of the Fourteenth Amendment Due Process Clause, face precisely this definitional task. Applying relevant precedents, "distinguish[ing] [other cases] according to real distinctions," and parsing only at the "natural joints" of the juridical concept being assessed, are particularly vital steps in the state action arena. This is so, not least of all, because of the reflexive tendency by some courts to reason that a complainant's "expectation of procedural due process" is tantamount to a guarantee of such protection whenever any state involvement is present, no matter how attenuated it may be.

In the instant case, the Third Circuit's assessment of this Court's relevant precedents missed the mark in dramatic ways. Indeed, with due respect, the lower court's resolution of the issue of Petitioners' status as state actors *vel non*, cannot escape comparison to Plato's "inefficient butcher." The court's decision carves not at the "natural joints" of the state action doctrine, but according to artificial or illusory distinctions. Stark proof of this is the court's theory that Petitioners are state actors because Pennsylvania's regulation of the state workers' compensation system constitutes a "complex and interwoven

regulatory web." Pet. App. at 14a. This factual characterization becomes the vital predicate of the lower court's belief that relevant state action decisions of this Court are wholly inapposite. Bereft of the moorings those cases provide, the Third Circuit's holding becomes incoherent.

Instead, Petitioners do not qualify as state actors, and this case can be decided by resort to those precedents where the Court has determined that no constitutionally-cognizable state action exists, notwithstanding the presence of the state regulatory regime in question. Accordingly, the Third Circuit's conclusion to the contrary must be reversed.

ARGUMENT

I. ANALYTICAL PARAMETERS OF THE STATE ACTION DOCTRINE

The Third Circuit's ruling that workers' compensation insurers become "state actors" for due process purposes when they rely on Pennsylvania's benefits review procedure, is erroneous. The court's error results from a failure to discern the logical contours or "natural joints" of the state action doctrine. This basic confusion produced a distorted analytical framework for assessing the significance, for due process purposes, of Petitioners' use of the review procedure. With that initial misstep, the lower court's analysis was irrevocably skewed (*see* Section II, *infra*.)

It did not have to be that way. As we discuss below, a valid construct for the state action doctrine emerges straightforwardly from its textual and logical underpinnings. Focusing on these foundation points helps ensure that the

analysis begins from a valid orientation and that it develops coherently. *See, e.g.*, C. Black, STRUCTURE AND RELATIONSHIP IN CONSTITUTIONAL LAW (1969) (Arguments from structure and relationship support constitutional conclusions on the basis of their fit with, or their entailment by, the necessary presuppositions of the governmental structure the Constitution creates).[2] This Court's cases generally are in harmony with this approach, notwithstanding that the decisions have sometimes produced theories of state action with varied emphases. After showing that the Third Circuit's *ratio* is an aberration, we suggest in Section III certain refinements to state action doctrine that may aid lower courts in their analyses.

***

1. *Structural Considerations*. The federal Constitution's core function is to provide a framework for national republican self-governance. The Constitution "concerns itself almost exclusively with the creation of federal governmental bodies, the allocation of governmental power among those federal bodies and the states, and the limitation of that governmental power at both the state and federal levels." H. Strickland, *The State Action Doctrine and the Rehnquist Court*, 18 Hastings Const. L.Q. 587, 591 (1991).

With rare exception, the Constitution does not govern or

[2] Perhaps the most famous example of structural argument comes from Chief Justice Marshall's opinion in *McCulloch v. Maryland*, 17 U.S. (4 Wheat.) 316 (1819), forbidding state taxation of federal entities on the ground that the power to tax is the power to destroy. *Id.* at 427. With the state and national governments structured as they were under the Constitution, it would make no sense, Marshall reasoned, for the state to be able to frustrate constitutionally legitimate federal policies.

regulate the affairs of individuals and private entities, such as Petitioners. Rather, "it establishes the structure through which, and the limits within which, governmental bodies regulate the daily activities of individuals and define their rights and responsibilities *vis-a-vis* their neighbors." *Ibid.* These rights among private citizens owe their existence to legislation and state common law, not to the Constitution.

Consistent with these purposes, the individual rights and liberties guaranteed by the Constitution are, for the most part, freedoms from certain kinds of *governmental action*.[3] Indeed, of the constitutional rights that are self-executing — those capable of enforcement by courts even without specific congressional legislation to enforce the right — only the Thirteenth Amendment's prohibition of slavery directly restricts the actions of private citizens. Accordingly, "as a matter of substantive constitutional law, the state action requirement reflects judicial recognition that 'most rights secured by the Constitution are protected only against infringement *by governments*.'" *Flagg Bros. v. Brooks*, 436 U.S. 149, 156 (1978) (interior citation omitted).

This "fundamental fact of our political order," *Lugar v. Edmondson Oil Co.*, 457 U.S. 922, 937 (1982), cannot be overestimated. In virtually any litigation in which an individual contends that his constitutional rights have been violated, the court can grant relief *only* if it finds action by or attributable to

[3] The first eight Amendments apply, expressly or impliedly, only to actions of the federal government. Similarly, the Fourteenth Amendment Due Process and Equal Protection Clauses expressly apply only to state governments. With the exception of the Thirteenth Amendment, constitutional liberties apply to only governmental actions.

the state. *Rendell-Baker v. Kohn*, 457 U.S. 830, 836 (1982) ("The Court has insisted that the conduct allegedly causing the deprivation of a federal right be fairly attributable to the State"). In other words, "[i]f the conduct is not that of the state, then it *cannot be unconstitutional*, because the Constitution applies only to state action." Strickland, *supra,* at 617 (emphasis added). This limiting facet of the state action doctrine — one of its important "natural joints" — has crucial pragmatic consequences. If state action and private action cannot, by definition, coalesce — then, *a fortiori*, the range of state action cases is determinate, even in the modern regulatory state.

2. Constitutional Values Underlying the State Action Doctrine. Within this structural context, at least two further constitutional values operate. First, the "state action" requirement "preserves an area of individual freedom by limiting the reach of federal law and federal judicial power." *Lugar*, 457 U.S. at 936.[4] Accordingly, valid state action analyses explicitly recognize that this protected value is, by the very nature of the issue, always extant in such cases. As the Court put the point in *Lugar*, "Freedom of the individual to choose his associates or his neighbors, to use and dispose of his property as he sees fit, to be irrational, arbitrary, capricious, even unjust in his personal relations are things all entitled to a large measure of protection from governmental interference." 457 U.S. at 936-937. Thus, private parties can be held liable for alleged due process violations only if "it can fairly be said that

[4] Correlatively, the state action doctrine "avoids imposing on the State, its agencies or officials, responsibility for conduct for which they cannot fairly be blamed." *Lugar*, 457 U.S. at 937.

the [government] is responsible for the specific conduct of which the plaintiff complains." *Blum v. Yaretsky*, 457 U.S. 991, 1004 (1982).

Relatedly, there is also inherent in the concept of state action the values of federalism and separation of powers — a recognition that there are areas of private rights as to which federal power "should not lay a heavy hand and which should properly be left to the more precise instruments of local authority." *Peterson v. City of Greenville,* 373 U.S. 244, 250 (1963) (Harlan, J. concurring). Consequently, courts are required "to respect the limits of their own power as directed against . . . private interests." *Lugar*, 457 U.S. at 937. *See also, Hammer v. Dagenhart*, 247 U.S. 251 (1918) (The Court has "no more important function than . . . the obligation to preserve inviolate the constitutional limitations upon the exercise of authority, [both] federal and state . . .").

3. These considerations illumine the "natural joints" of the state action doctrine in several ways, critical for courts to keep in focus as they adjudicate state action cases. *First*, the state action doctrine makes *these particular* values (individual liberty and federalism) *logically prior* to others that a plaintiff may wish to invoke. This means the approach in state action analyses must be distinguished from "balancing" formulas in related contexts. For example, a plaintiff's expectation of procedural due process is, in many contexts, a constitutional value that is weighed in the balance against other values, such as the interests of the state. This, of course, is the conceptual presupposition that underlies constitutional "balancing" tests of the kind articulated by the Court in such cases as *Matthews v. Eldridge*, 424 U.S. 319 (1976). In these cases, the plaintiff's expectation of the availability of due process relief is, by the

nature of the case, a fully instantiated constitutional interest. Whether the plaintiff is entitled to the due process procedures he seeks is thus a matter of comparing the "weight" of his interest to the conflicting or incompatible (but equally instantiated) interests of the state. The judicial test by which that comparison proceeds does *not* presuppose that the interests of one side or the other are *logically prior*. (If it did, the "balancing" would be an illusion.) Therefore, the plaintiff's *expectation* of due process is, in that setting, analytically equivalent to his *interest* in due process.

But that is not how the state action doctrine operates. Here, the extent of a plaintiff's constitutional interest in due process is *not* a factor, in the first instance, in a court's inquiry as to whether state action is present — and thus whether a constitutional case or controversy exists at all. Unless courts begin with the key premise that the purpose of the requirement is to ensure against subjecting a private entity's actions to constitutional scrutiny in the absence of state action, there is the risk that a plaintiff's desire for due process will be seen as a competing value in a court's threshold appraisal of the defendant's status as state actor *vel non*. *See, e.g., Lugar*, 457 U.S. at 937 ("This liberty would be overridden in the name of equality, if the structures of the amendment were applied to governmental and private action without distinction"). This is a particularly vexing risk in a case such as the instant one, where a consumer's expectation of due process may be a widespread perception throughout society. But vexing or not, the values that underlay the state action doctrine fix its contours, and can be ignored only at the risk of incoherence. *See, e.g., Regents of Univ. of Calif. v. Bakke*, 438 U.S. 265, 299 (1978) (plurality opinion of Powell, J.) (Courts must discern "principles sufficiently absolute to give them roots throughout

the community and continuity over significant periods of time, and to lift them above the level of pragmatic political judgments of a particular place and time").

Second, if a court intuitively proceeds as if a plaintiff's claim of due process is an already-concrete interest to be "weighed in the balance," there is a danger that the court might view its resolution of the issue as dependent on the "unique facts and circumstances" of the case, rather than be guided by a general rule of law. This opens the door for a court to act with undisciplined discretion; to react viscerally or intuitively to a case that may, in fact, have "equities" favoring the plaintiff, but is devoid of genuine state action. *See, e.g.*, A. Scalia, *The Rule of Law As a Law of Rules*, U. Chic. L. Rev. 1175 (1989) ("[W]hen balancing is the mode of the analysis, not much general guidance may be drawn from the opinion, *id.* at 1186. *** In the real world of appellate judging, it displays more judicial restraint to adopt a general principle than to announce that, 'on balance,' we think the law is violated here — leaving ourselves free to say in the next case that, 'on balance,' it was not. Only by announcing rules to we hedge ourselves in." *Id.* at 1179).

2. Although these conceptual pitfalls should be obvious, errors among the lower courts may be exacerbated by the Court's occasional statements in state action decisions, that lower courts proceed on a case by case basis, "sifting facts and weighing the circumstances" for signs of the "nonobvious involvement of the State in private conduct." *Burton v. Wilmington Parking Authority*, 365 U.S. 715, 722 (1961). If lower courts interpret this as meaning that they have substantial discretion to employ a variety of "tests" for assessing state action claims, depending on how they view the weights of

opposing values and interests, substantially divergent opinions inevitably result. *See, e.g., Camp Newfound/Owatonna, Inc. v. Town of Harrison*, 117 S.Ct. 1590, 1620 (1997) (critical that "open-ended balancing tests . . . have allowed us to reach different results," but "not on any distinction derived from the test of the Constitution itself").

A prominent example of a Supreme Court decision that is susceptible to such misapplication is Justice Clark's opinion in *Burton, supra*. The Court there considered whether a private restaurant that rented space from a city-owned building was subject to the race-discrimination proscriptions of the Fourteenth Amendment. The case turned on whether the contacts between the city authorities and the restaurant were sufficient to constitute state action.

What is remarkable about this opinion is the absence of criteria that would resolve doubts about the application of "state action" — the key legal concept at issue. On one hand, Justice Clark acknowledged that, "[o]wing to the very 'largeness' of government, a multitude of relationships might appear to some to fall within the Amendment's embrace." *Id.* at 722. He then tries to forfend that conclusion, by elaborating, "[B]ut that . . . can be determined only in the framework of the peculiar facts or circumstances present. Therefore, respondents' prophecy of nigh universal application of a constitutional precept so peculiarly dependent for its invocation upon appropriate facts fails to take into account 'differences in circumstances [that] beget appropriate differences in law.'" *Ibid.*[5] That qualification, however, does not express a

[5] Justice Clark concluded: "Specifically defining the limits of our inquiry, what we hold today is that when a State leases public property in the manner and for the purpose shown to have been the case here, the proscriptions of the Fourteenth Amendment must be complied with by the lessee as certainly as though they were binding covenants written into the agreement itself." *Id.* at 725-26 (citations omitted).

meaningful principle or general rule of interpretation. It is as if the majority did not have any rule at all in mind — no genuine confidence in just where the "natural joints" of the state action doctrine fell — and invoked "appropriate differences in law" as a place-holder for an intelligible precept. As both Justice Harlan in dissent and commentators immediately noticed, the opinion lacks sufficient clarity as to what kinds of contacts between the state and private enterprises would come within the scope of the state action requirement as conceived by the *Burton* majority. Thus, a lower court's reliance on *Burton*'s rationale can create confusion, if the court does not have clearly in focus at the start the values the state action requirement serves. As shown below, the Court's recent precedents plainly reflect these important considerations.

II. THE COURT'S RECENT PRECEDENTS REFLECT THE VALUES UNDERLYING THE STATE ACTION DOCTRINE.

1. The Court's recent state action cases model the interplay of these analytical parameters in various fact patterns involving state regulatory structures. Several decisions during the last twenty years clearly hold that the actions of a private entity are not state action subject to the Fourteenth Amendment just because the entity is subject to general state regulation, even if the regulations are pervasive. *Jackson v. Metropolitan Edison Co.*, 419 U.S. 345 (1974), one of the most often cited

decisions articulating this rule, applied the rule to an electric utility's actions. The plaintiff in *Jackson* alleged that the defendant electric utility violated the Due Process Clause by disconnecting her electric service for nonpayment of her bill without providing a hearing. Conceding that the state subjected the utility to "extensive and detailed" regulation, the Court held that "[t]he mere fact that a business is subject to state regulation does not by itself convert its action into that of the State for purposes of the Fourteenth Amendment." *Id.* at 350.

Although the actions of heavily regulated industries perhaps will be more readily deemed state action, the Court continued, the presence of the general regulatory scheme as such does not produce that result. Rather, there must be "a sufficiently close nexus between the State and the challenged action of the regulated entity so that the action of the latter may be fairly treated as that of the state itself." *Id.* at 351. In the context of treating regulated private entities as state actors, this nexus requirement means that the regulations must in some way *involve the state directly* in the challenged activity.

Rendell-Baker v. Kohn, 457 U.S. 830 (1982), is a further application of this rule. The defendants in that case were a private school and its officials. The school specialized in helping students with difficulties completing public high school. State agencies referred most of the students to the school, and state funds accounted for most of the school's budget. In addition, a variety of government agencies extensively regulated a wide range of the school's activities. Nonetheless, the Court held that the school's discharge of the plaintiff, a counselor at the school, was not state action because the state's framework did not regulate such personnel matters

as the discharge of counselors.[6]

This orientation is in full harmony with the constitutional values discussed in Section I. *Jackson* and *Rendell-Baker* thus illustrate holdings where the Court has parsed the state action doctrine at its "natural joints." The Court deems private conduct to be state action on the basis of state regulation only if the regulations involve the state in or directly impact the challenged activity itself. For example, in *Peterson v. Greenville*, 373 U.S. 244 (1963), the Court held that the state *was responsible* for a restaurant owner's decision not to serve blacks, because a city ordinance required racial segregation in public eating places. Because the restaurant's management "did precisely what the city law required," *id.* at 250, the initiative for the discrimination came from the state. The Court concluded that such state imposed segregation clearly violated the Equal Protection Clause.

No recent decisions of this Court have held private conduct to be state action on the basis of state regulation. Of course, state regulation of private activities apparently may still result in private conduct's being deemed state action. This theoretical prospect is consistent with the conceptual

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[6] In *Rendell-Baker*, the private school received "problem" students referred to it by public institutions, it was heavily regulated, and it received between 90 and 99 percent of its operating budget from public funds. In *Blum*, the nursing home had most of its operating and capital costs subsidized by public funds and more than 90 percent of its residents had their medical expenses paid from public funds. In setting reimbursement rates, the state included a formula to assure the home a profit. Nevertheless, in both cases, the Court found that the entities remained private and required plaintiffs to show that the state was involved, either through coercion or encouragement.

underpinnings of the state action requirement. The Court has never overruled *Peterson* and continues to cite it with approval. *See, e.g., Moose Lodge No. 107 v. Irvis*, 407 U.S. 163 (1972) (regulation requiring private clubs to adhere to by-laws held to violate Equal Protection Clause because by-laws called for racial discrimination in guest policies) The Court's opinions, however, concentrate on *defining the limits* of the state action in the regulatory context. Thus, in *Blum v. Yaretsky*, 457 U.S. 991 (1982), the Court stated that "a State normally can be held responsible for a private decision only when it has exercised coercive power or has provided such significant encouragement, either overt or covert, that the choice must in law be deemed to be that of the State." *Id.* at 1004. *See also, Rendell-Baker*, 457 U.S. at 840-841; *Jackson*, 419 U.S. at 357. These opinions indicate that the Court will treat private conduct as state action if the state compels the conduct or significantly encourages the conduct in some way.

Indeed, the *Blum* decision raises doubt that any regulation short of a specific directive to perform the challenged action or to make the challenged decision will suffice to treat the activity as state action. The plaintiffs in *Blum* were Medicaid patients who were involuntarily discharged from nursing homes or transferred from one level of nursing home care to another. They alleged that the decisions of their nursing homes to discharge or transfer them violated the Due Process Clause because they were not provided notice or an opportunity for a hearing. The nursing homes made the transfer decisions only because New York and federal Medicaid regulations require periodic assessment of whether Medicaid recipients are receiving the appropriate level of care. The regulations required the nursing homes to "'maintain a discharge planning program to . . . document that the facility has made and is continuing to

make all efforts possible to transfer patients to the appropriate level of care or home as indicated by the patient's medical condition or needs." *Id.* at 993. Moreover, the nursing homes were subject to sanctions if they failed to assign Medicaid patients to the level of care the State deems appropriate. The purpose of the procedures, including the multiple levels of nursing home care, the need assessments, and the transfer decisions, was to control and reduce the cost of the Medicaid program to the state. The nursing homes would not make the assessments or initiate the transfers but for the state regulations requiring them to do so, in order to serve the state objective of controlling Medicaid costs.

Nevertheless, the Court held that the nursing homes' decisions to transfer the plaintiffs to another level of care was not state action because the "decisions ultimately turn on medical judgments made by private parties according to professional standards that are not established by the State." *Id.* at 1008. Thus, "while the State commands the making of some decision," sets criteria for the decision, and imposes sanctions for making the decision incorrectly, "it still is not responsible for the specific decision made, which inevitably turns on an independent medical judgement." *Ibid.*

The state's regulatory role in *Blum* was insufficient to make the nursing homes' transfer decisions state action. This suggests that the logical contours of the state action doctrine require "state regulatory involvement or encouragement in the nature of a specific directive to make a specific decision or perform a specific act."[7] Strickland, *supra*, at 622.

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[7] *See also, Flagg Bros. v. Brooks*, 436 U.S. 149 (1978). In that case, a warehouseman proceeded under the New York Uniform

Whatever level of state regulatory involvement is required to deem the action of a regulated entity state action, state action exists only because of the state regulatory involvement. Unless the private conduct is an exclusive function of the sovereign the private entity is free to engage in the challenged conduct on its own initiative. In effect, therefore, the state regulation — not the private conduct pursuant to the regulation — is the state action. In short, private activities or decisions are state action under the Fourteenth Amendment when state regulations specifically compel the challenged action or decision.

2. *The Third Circuit's Rationale Conflicts With These Principles*. In the instant case, the Third Circuit purported to "place the insurer's role within the Workers' Compensation system in context." Pet. App. at 13a. The court identified what it took to be the "key features" of the system: that no-fault compensation applies to all employees within the state; that employees lose the right to sue their employers in tort, so that the workers' compensation scheme is the exclusive remedy for injured workers; that the system is mandatory; and that the state guarantees that benefits will be paid. These features, said the court, show that the state extensively regulates and controls the

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Commercial Code, and the debtor challenged the constitutionality of that provision on the grounds that it violated the Due Process and Equal Protection Clauses of the Fourteenth Amendment. Plainly the state was responsible for the statute. The response of the Court, however, focused not on the terms of the statute but on the character of the defendant to the § 1983 suit: Action by a private party pursuant to this statute, without something more, was not sufficient to justify a characterization of that party as a "state actor."

workers compensation system, and that it thus constitutes a "complex and interwoven regulatory web." *Id.* at 14a.

Although insurance companies are private entities, "when they act under the construct of the Workers Compensation system, they are providing public benefits which honor State entitlements. In effect, they become an arm of the State, fuifilling a uniquely governmental obligation under an entirely state-created public benefit system." *Id.* at 15a. Thus, insurance companies are "a partner or arm of the State in implementing legislation that administers const protected entitle which the Commonwealth has enacted as a matter of policy." *Ibid.* The right to stop payments is a power that traditionally was held in the hands of the State. Insurers have no power to deprive or terminate such benefits without the permission and participation of the state. Finally, the state is intimately involved in the suspension decision because "an insurer cannot suspend medical payments without first obtaining authorization from the Bureau." *Ibid.*

The Third Circuit noted the state action cases discussed above, but deemed them inapposite. It did so on the ground that those decisions, "do not, by the very nature of the controversies with which they dealt, involve a comprehensive statutory scheme similar to that present in this case." Id. at 18a.

The Third Circuit's decision illustrates the effect of a court's neglecting to parse the state action requirement at its "natural joints." Here, the lower court did little more than list perceived ties between the government and the Petitioners' challenged conduct, and then announce the conduct to be state action. That approach carries no more substance than saying that the private entity's conduct is state action because it ought

to be deemed state action — merely an opaque tautology. Not surprisingly, therefore, the internal logic of the lower court's opinion collapses. Conceptually, it is impossible to discern in a principled fashion any difference between the suspension of insurance payments under the Pennsylvania statute, and the termination of electric service in *Jackson* or termination of care through patient discharges or transfers in *Blum*. The Pennsylvania statute merely permits private parties to withhold payments to health care providers during the benefits review. That process is conducted not by state officials but by medical professionals employed by private organizations. The decision to withhold payment of disputed medical bills is made entirely by Petitioners, with no coercion or encouragement by the state. In this sense, it cannot be distinguished from the decision of any party to withhold contract payments until a dispute is resolved.

Not surprisingly, the Third Circuit intones language eerily reminiscent of Justice Clark's opinion in *Burton*. While failing to articulate a legal principle that would lead to a valid conclusion, the court nonetheless "expressly limit[s] our holding . . . to the unique context" of the case. The court's decision thus lacks sufficient coherence to permit review using the conceptual framework that has evolved as this Court's state action doctrine. The Third Circuit's decision is, for that reason, genuinely arbitrary.

III. THE COURT SHOULD REITERATE THE VALUES THE STATE ACTION DOCTRINE SERVES, AND IN THE CONTEXT OF STATE REGULATORY REGIMES REQUIRE DIRECT INFLUENCE OR COERCION BY THE STATE.

In the instant case, Petitioners did no more than invoke a presumptively valid state procedure specifically designed as a legislative approach to cost containment. Apparently relying on a sort of "but for" analysis, the Third Circuit erroneously concluded that the procedural steps provided for by the Pennsylvania statute somehow transform Petitioners' acts into actions of the state. Invoking that procedure might be said, in the most strained sense, to implicate the state or its officers — but only by emptying "nexus" of any useful meaning. Transforming essentially private conduct into actions of the state by that means is adjudication by fiat.

To avoid this confusion, the Court should stress the importance of a lower court's articulating precisely what relationship between the state and the private entity is required for this conclusion and why that relationship justifies application of the Fourteenth Amendment to a private entity. The Court should also caution that "sifting facts and weighing the circumstances" in state action cases must be done with the values underpinning the state action doctrine firmly fixed in the analysis. The general rule that emerges from the Court's cases in the arena of state regulation — which calls for a showing that the state has involved itself in a direct, coercive way — will enable lower courts to parse state action according to their "natural joints." A state action formula that fails to begin with

that orientation neither guides courts in applying the Fourteenth Amendment to governments' efforts to act with or through private entities, nor prevents courts from intruding upon the political branches' exclusive authority to regulate private activity.

CONCLUSION

The judment of the Third Circuit should be reversed.

Respectfully submitted,

Daniel J. Popeo
Paul D. Kamenar
WASHINGTON LEGAL FOUNDATION
2009 Massachusetts Ave., NW
Washington, DC 20036
(202) 588-0302

Ronald D. Maines
Counsel of Record
MAINES & LOEB, PLLC
1827 Jefferson Place, NW
Washington, DC 20036
(202) 293-5333

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AMERICAN MANUFACTURERS MUTUAL INSURANCE COMPANY, *et al.*,
Petitioners,
v.
DOROTHY SCOTT SULLIVAN, *et al.*,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Third Circuit

BRIEF OF AMICI CURIAE PENNSYLVANIA TRIAL LAWYERS ASSOCIATION, THE ASSOCIATION OF TRIAL LAWYERS OF AMERICA AND THE WORKPLACE INJURY LITIGATION GROUP, INC. IN SUPPORT OF RESPONDENTS

MARK S. MANDELL
President of
The Association of Trial Lawyers of America
JEFFREY WHITE
Associate General Counsel
Office of General Counsel
of The Association of Trial Lawyers of America
1050 31st Street, N.W.
Washington, D.C. 20007
(202) 965-7500
Counsel for Amici Curiae, The Asssociation of Trial Lawyers of America

MICHAEL J. FOLEY
Counsel of Record
FOLEY, MCLANE, FOLEY, MCDONALD & MACGREGOR
Linden Plaza, 600 Linden Street
P.O. Box 1108
Scranton, Pennsylvania 18501-1108
(717) 342-8194
Counsel for Amici Curiae, The Pennsylvania Trial Lawyers Association, The Association of Trial Lawyers of America, and The Workplace Injury Litigation Group, Inc.

(Additional Counsel Listed on Inside Cover)

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RICHARD A. KIMNACH
ANESI, OZMON, RODIN,
NOVAK & KOHEN, LTD.
Suite 2100 21st floor
161 N. Clark
Chicago, Illinois 60601
Counsel for Amici Curiae
The Workplace Injury
Litigation Group, Inc.

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IN THE
Supreme Court of the United States
OCTOBER TERM, 1998

No. 97-2000

AMERICAN MANUFACTURERS MUTUAL INSURANCE COMPANY, *et al.*,
Petitioners,
v.
DOROTHY SCOTT SULLIVAN, *et al.*,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Third Circuit

BRIEF OF AMICI CURIAE PENNSYLVANIA TRIAL LAWYERS ASSOCIATION, THE ASSOCIATION OF TRIAL LAWYERS OF AMERICA AND THE WORKPLACE INJURY LITIGATION GROUP, INC. IN SUPPORT OF RESPONDENTS

INTEREST OF AMICI CURIAE [1]

The Association of Trial Lawyers of America ["ATLA"] is a voluntary, national bar association. Most of its 50,000+ members represent injured plaintiffs, including

[1] Pursuant to Supreme Court Rule 37.6, Amici Curiae state that no counsel for any party to this dispute authored this brief in whole or in part and no person or entity other than Amicus Curiae made a monetary contribution to the preparation or submission of this brief. Written blanket consensus to the filing of this and other amici briefs in this proceeding have been filed with the Clerk.

those who have suffered their injuries as a result of their employment.

The Workplace Injury Litigation Group, Inc. ["WILG"], an independent offshoot of the ATLA, is likewise a nationwide association of attorneys. Its members practice almost exclusively in the field of workers' compensation on behalf of injured employees.

The Pennsylvania Trial Lawyers Association (PATLA), is a non-profit professional organization with approximately 4,000 attorney members. While there are no restrictions on membership, the majority of the Association's attorneys are actively involved in civil litigation among which cases include workers compensation litigation. One of the principal functions of the Association is the advancement of the law through Amicus Curiae and education programs. In this respect, the Association has an abiding interest in the development of case law under the Pennsylvania Workers' Compensation Act. The Association has for at least 15 years supported extensive seminar programs regarding the Pennsylvania Workers' Compensation Act.

The Amici believe that the Court of Appeals for the Third Circuit was correct in its interpretation of this case as it defines both "state action" and "due process" in its application to the factual context. Rather than cover the arguments ably addressed by the Respondents, Sullivan et al., Amici hope to set forth the basis for the unique statutory framework of workers' compensation benefits in Pennsylvania. Amici seek to dispel the argument that entitlement to medical benefits and the resulting access to uninterrupted medical care simply involves private insurance contract disputes over benefits which Petitioner insurer's allege are not subject to constitutional limitation by the due process clause of the Fourteenth Amendment of the United States Constitution and 42 U.S.C. § 1983.

INTRODUCTION

On July 2, 1993, the Pennsylvania Legislature enacted Act 44 of 1993 which primary features included a number of statutory provisions designed to cut medical costs in the workers compensation system. 77 P.S. § 1 et seq. and § 531 (1993) (Historical and Statutory Notes). These procedures were varied, but the most significant provided that medical fees shall be capped at 113% of the Medicare reimbursement applicable in Pennsylvania under the Medicare program for comparable services. 77 P.S. § 531(3)(i) (1993). Major costs savings were realized by limiting reimbursement for prescriptions and pharmaceutical services to 110% of the average wholesale price of the product. 77 P.S. § 531(3)(vi) (1993). Coordinated care organizations were authorized. 77 P.S. § 29, § 531(4), § 531.1 (1993). Captive treatment periods that required employees to treat with the company doctor were expanded from 14 days to 30 days from the date of the first visit.[2] 77 P.S. § 531(1)(i) (1993). Health care provider self-referrals and cross-referrals were prohibited. 77 P.S. § 531(3)(iii) (1993). One of the cost containment aspects of the Act 44 amendments of 1993 involved the creation of a utilization review procedure which is the subject of the Petitioner insurers' appeal from the Third Circuit Court of Appeals decision below. 77 P.S. § 29, § 531(5) and (6)(i) (1993).

The 1993 amendments excluded compensation for injuries sustained while an employee was driving an em-

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[2] In Act 57 of 1996, the captive treatment period was extended to 90 days, 77 P.S. § 531(1)(i) (1996). In Act 57 of 1996, the Pennsylvania legislature substantially expanded cost cutting for wage loss isssues in the Pennsylvania Worker's Compensation system, providing tremendous long term savings for insurance companies and SWIF. See Historical and Statutory Notes, 77 P.S. § 1 *et seq.* and 77 P.S. §§ 511.2, 512, 531, 582 (1996). In 1995, the Pennsylvania legislature rewrote 77 P. § 512, which significantly limited the compensability of hearing loss for Pennsylvania workers.

ployers motor vehicle but was not otherwise in the course of employment at the time of injury (77 P.S. § 481); granted insurers subrogation in auto accident cases by repealing 75 Pa. C.S.A. § 1720, entitled *Subrogation*, and § 1722; *Schroeder v. Schroeder*, 453 Pa. Super. 59, 682 A.2d 1305 (1996); suspended compensation for incarcerated claimants, (77 P.S. § 511 (1993); reenacted at 77 P.S. § 511.1)); limited compensation for professional athletes, (77 P.S. § 565); excluded compensation for intentionally self-inflicted injury, injury caused by violation of the law, or use of illegal drugs (77 P.S. § 431), and/or intoxication if the employer establishes "but for causation". (77 P.S. § 431.)

The Third Circuit concluded that the utilization review provision contained in Act 44. 77 P.S. § 531(5) and (6) were unconstitutional. These provisions added a utilization review procedure which allow insurers and self-insurers to suspend payment of medical benefits of thousands of workers without *any* notice and without *any* predeprivation opportunity to be heard while the review is pending. *Sullivan v. Barnett*, 139 F.3d 158 (3rd Cir. 1988), cert. granted,

SUMMARY OF THE ARGUMENT

Pennsylvania has enacted a public benefit system through the Pennsylvania Workers' Compensation Act designed to provide the exclusive remedy for injured workers seeking compensation and medical benefits from employers and their insurers for all work place injuries. Amici submit that the decision of the Third Circuit Court of Appeals was correct in holding that constitutional limitations apply to the actions: (1) of the Commonwealth of Pennsylvania in enacting the cost containment provisions of Act 44 of 1993, and (2) to parties implementing these, including insurers and employers, in suspending medical benefits, by invoking the utilization review process contained in Act 44 because they are state actions in this context.

The Third Circuit Court of Appeals decision correctly concluded that the actions of SWIF, private insurers and self-insureds of suspending payment for medical care after initiating utilization review with the approval of the Pennsylvania Department of Labor and Industry, is an unconstitutional violation of procedural due process protected by the Fourteenth Amendment because the supersedeas provision of 77 P.S. § 531(5) and (6) do not afford disabled employees *any* notice or an opportunity to be heard before their benefits are suspended.

Further, Amici respectively suggest that the remedy suggested by the Third Circuit, which has since been instituted by the Pennsylvania Department of Labor and Industry since the decision below was announced, is a minimal and reasonable requirement for ensuring procedural due process of law to disabled Pennsylvania workers seeking medical care for concededly work related injuries. The Third Court stated that a disabled worker must be given:

> "(1) timely and reasonable notice of imminent suspension of the medical benefits and treatment before the suspension takes effect; (2) a description of the reasons why utilization review has been invoked; (3) an opportunity and time to submit a personal statement in writing regarding the employees view of the reasonableness and/or necessity of the disputed medical treatments; and (4) a description of the procedures under which the employee can appeal an adverse determination."

139 F.3d at 178.

These minimal burdens placed on employers and insurers invoking utilization review in the Pennsylvania Workers' Compensation system will reduce the significant risk of erroneously terminating or suspending an employee's medical benefits and access to medical care when and as needed, a property right recognized under Pennsylvania law. *Sullivan v. Barnett*, 139 F.3d at 176, 178. Affording Pennsylvania's disabled workers with procedural

due process in the utilization review process has since been instituted in Pennsylvania with little difficulty or expense or adverse effect on insurers. The decision of the Third Circuit below leaves undisturbed significant constitutional means of promoting the state's interest of controlling health care costs for treatment of work related injuries, including establishing medical fee caps of 113% of Medicare reimbursement for medical services, and reimbursement for prescription drugs and pharmaceutical services at 110% of the average wholesale price of the product, among others.

ARGUMENT

In The Context Of The Public Benefit System Of The Workers Compensation System In Pennsylvania, The Petitioner Insurers' Suspension Of Payment For Medical Care, In Accordance With The Act 44 Of 1993 Amendments To The Pennsylvania Workers' Compensation Act, Which Did Not Afford Disabled Workers *Any* Predeprivation Notice Or Opportunity To Respond Before Suspension Takes Place, Constitutes State Action And Violates Procedural Due Process Of Law Guaranteed By The Fourteenth Amendment.

In 1915, the Pennsylvania legislature amended the Pennsylvania Constitution Article III, § 18 to allow the government to implement a comprehensive workers compensation system, the Workers' Compensation Act of 1915. *DeJesus v. Liberty Mutual Insurance Co.*, 439 Pa. 180, 268 A.2d 925, 926 (1970). The language chosen in the enactment of Article III, Section 18 was to ensure "an employee's need to be compensated for his or her work related injuries." *Grosser v. L.E. Smith Glass Co.*, 95 Pa. Cmwlth. 450, 505 A.2d 1093 (1986) (en banc). The Pennsylvania Supreme Court has stated that proceedings in workmen's compensation cases "are essentially of a judicial character." *See Shortz v. Farrell*, 327 Pa. 81, 193 A. 20, 22 (1937).

Administering this "obligation imposed by statute on employers", (*Hankee v. Wilkes-Barre Scranton International Airport*, 532 Pa. 494, 616 A.2d 614, 619 (1992)), is "purely" an exercise of the "police power" of the Commonwealth regulating the employer-employee relationship. (*Bible v. Com. Dept. of Labor and Industry*, 548 Pa. 247, 696 A.2d 1149, 1153 (1993)). In order to provide for this system of public benefits by which all employees become entitled as an incident of employment in Pennsylvania, "it was necessary to amend the Constitution of the Commonwealth to give the authority to enact it. *See* Pa. Const. Art. III, Sec. 18., *Hankee*, 616 A.2d at 617 n.6. [I]n determining the nature of the benefits it cannot be ignored that the employer is obligated to provide the compensation without regard to the obtaining of insurance . . ." *Hankee, supra*, 616 A.2d at 617.

"Compensation" under the Pennsylvania Workers' Compensation Act includes "payment for reasonable surgical and medical expenses . . . . *as and when needed* . . ." 77 P.S. § 531(1) (1978). See, *Reilly v. W.C.A.B. (General Elec. Co.)*, 98 Pa. Cmwlth. 488, 512 A.2d 749 (1986), app. den. 514 Pa. 651, 524 A.2d 496, app. rem. 136 Pa. Cmwlth. 543, 584 A.2d 364 (1991) (medical expenses constitute compensation). The amendments to 77 P.S. § 531(1) contained in Act 44 of 1993 continue to express a legislative intent to provide reasonable and necessary medical treatment for injured workers in Pennsylvania as and when needed:

> "The employer shall provide payment in accordance with this section for reasonable surgical and medical services . . . *as and when needed*."

Id.

Like the state's obligations to inmates in *West v. Atkins*, 487 U.S. 42 (1988), the Commonwealth of Pennsylvania has an obligation under the Pennsylvania Workers' Compensation Act to ensure adequate access to medical care for workers whose rights have been restricted by the Act's exclusive remedy provision. 77 P.S. 481. Shifting this obligation to the charity of the health care

industry is *not* adequate nor proper.[3] In the proposed rulemaking published by the Department of Labor and Industry (34 Pa. Code Chs. 121 and 127, published Pennsylvania Bulletin, Vol. 24, No. 30, July 23, 1994), the Commonwealth of Pennsylvania reaffirmed this duty wherein it stated that "these proposed regulations ensure that individuals with work related injuries and illnesses continue to have adequate access to quality medical care in this Commonwealth." *Id.*

It is well settled in Pennsylvania that medical benefits are payable "as and when" needed by the provisions of the Act regardless of whether the claimant is working, is receiving, or has received wage loss disability benefits. *Deremer v. W.C.A.B. (R.S. Glass, Inc.)*, 61 Pa. Cmwlth. 415, 433 A.2d 926 (1981). The choice of the statutory words "as and when needed" clearly were chosen to ensure uninterrupted continuity of care. Pennsylvania does not require that medical treatment restore earning power. Treatment for the alleviation of pain is a sufficient basis to establish reasonableness and necessity of medical care. In 1972 and 1978, the Pennsylvania legislature amended the Act to make clear that the reasonable and necessary medical treatment is compensable, whether or not, restoration of earning power occurs. The Act does not, as the Amici Curiae American Insurance Association, et al. claim, "limit treatment in accordance with a return-to-work objective." (Amici AIA et al., p.6). Allowing an injured worker's written statement explaining the efficacy of treatment in alleviating an individuals pain or modifying the severity of a workers symptoms to be submitted to the

[3] The American Medical Association Code of Medical Ethics does not regulate hospitals, drug stores, chiropractors, osteopaths, medical equipment suppliers or numerous other health care providers. Further, American Medical Association ethical guidelines do not provide a legally enforceable right or cause of action to patients. Likewise, Pennsylvania Medical Practice Act of 1985, P.L. 457, December 20, 1985 does not provide any private remedy to aggrieved patients. 63 P.S. § 422.1 et seq.

URO prior to deprivation is minimal due process required under the circumstances. *Sullivan v. Barnett*, 139 F.3d at 177 (3rd Cir. 1998) ("The personal written submissions of such disabled workers is critical to assessing the relative benefits that a particular treatment or practice might have.")

To make this point absolutely clear, in 1978 the Pennsylvania legislature amended Section 306(4) of the Act, 77 P.S. § 531(d) to state in pertinent part: "The provisions of this section shall apply in injuries whether or not loss of earning power occurs." Act of July 1, 1978 P.L. 692, No. 119 § 1, 77 P.S. § 531. *Deremer v. W.C.A.B.*, 61 Pa Cmwlth. 415, 433 A.2d 926 (1981). Accord *Tobias v. W.C.A.B. (Nature's Way)*, 141 Pa. Cmwlth. 438, 595 A.2d 781, 785 (1991) app. den., 529 Pa. 628, 600 A.2d 543 (1991) (expenses for both husband and wife related to artificial insemination when necessitated by sexual dysfunction caused by work-related spinal cord injury, are compensable under the Act.).

The 1993 amendments to 77 P.S. § 531 retained this language that "[t]he provisions of this section shall apply to injuries whether or not loss of earning power occurs." 77 P.S. § 531(1)(ii) (1993). The right to timely reimbursement for reasonable and necessary work-related medical care provides a disabled worker with a legitimate claim of entitlement which constitutes constitutional property. *See* e.g. *Board of Regents v. Roth*, 408 U.S 564, 577 (1972); *Baksalary v. Smith*, 579 F. Supp. 218 (1984) app. den. 469 U.S. 1146 (1985), aff'd 772 F.2d 893 (3d Cir. 1985) (Finding a person that already receives workers compensation benefits has a property interest in the continued receipt of such benefits.) In the decision below, the Third Circuit recognized that the "employees' interest is in the uninterrupted payment of their medical benefits pending the final administrative decision on their cases." *Id.* 139 F.3d at 774. Unsurprisingly, the Third Circuit below reasoned that injured workers have an interest in the relief that medical treatment provides:

"The remedies that the Act provides to an employee whose medical benefits are unjustly terminated provide merely superficial redress as they focus upon a monetary interest as distinct from a medical interest in one's well-being. Further, as medical benefits are typically terminated upon invocation of utilization review, the employee does not receive any medical treatment pending review and thus there may be no medical costs to reimburse upon a determination that the medical treatments were, in fact, reasonable and necessary. Once the supersedeas is invoked, it can take several months before the URO reaches its decision and—before the reconsideration process was rescinded—even longer if reconsideration review was requested. Although a monetary award may compensate an individual for financial losses, a monetary award cannot be deemed an adequate, effective, or appropriate substitute for relieving an employee's disability or pain. Nor can it be a substitute for necessary medical care. Hence, we are persuaded that the employees' private interest in receiving uninterrupted medical benefits is a weighty and significant factor in the pre-termination calculus."

139 F.3d at 175.

This is consistent with federal precedent establishing that timely medical attention is a basic necessity of life. *See e.g. Memorial Hospital v. Maricopa*, 415 U.S. 250, 259, 261 (1974).

As part of this system of public benefits, the legislature also established the State Workmen's Insurance Fund (S.W.I.F.) in 1915, recognizing the state's need to insure access to workers' compensation insurance for all Pennsylvania employers. SWIF was created for the purpose of insuring employers against liability under the Pennsylvania Workmen's Compensation Act. 77 P.S. § 221 (repealed 1996 and the subject matter subsequently modified

and re-enacted at 77 P.S. § 2621 et seq.)[4] *See also* 77 P.S. §§ 501, 701 (1978). All of SWIF's premiums are paid to the State Treasurer, who serves as custodian of the Fund. 77 P.S. §§ 223, 342 (1992).

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[4] The Pennsylvania legislature has in the past commingled SWIF and other state funds by using the SWIF surplus to help fund the general budget in 1988 and 1989. *See e.g.* Act No. 1988-56A, October 14, 1988, Appendix 1a. *Scranton Times*, February 10, 1988 "Reallocation Proposal Gets SWIF Board Nod." Appendix 9a. *Scanton Times*, March 10, 1988 "State Fund-Transfer Fund is Both Criticized and Praised"), Appendix 2a. On October 14, 1988, then Governor Casey signed Act 1988-56A which authorized the transfer of reserve funds of the State Workers Insurance Fund directly to the General Fund and the Treasury Department, thus demonstrating the symbiotic relationship inherent in the Pennsylvania Workers Compensation system. (*See* Act 1988-56A attached.)

The text of the Act 1988-56A provides:

Appropriating and transferring amounts from the State Workmen's Insurance Fund to the Treasury Department and the General Fund.

The General Assembly of the Commonwealth of Pennsylvania hereby enacts as follows:

Section 1. The following sums, or as much thereof as maybe necessary, are hereby appropriated from the State Workmen's Insurance Fund for the fiscal year beginning July 1, 1988:

(1) The sum of $25,000,000 is appropriated to the Treasury Department for transfer to the Sunny Day Fund.

(2) The sum of $25,000,000 is appropriated to the Treasury Department for transfer to the Tax Stabilization Reserve Fund.

Section 2: The sum of $60,000,000 is hereby transferred from the State Workmen's Insurance Fund to the General Fund.

Section 3: This act shall take effect immediately.

Approved—The 14th day of October A.D. 1988

ROBERT P. CASEY

In 1988, the General Assembly of the Commonwealth of Pennsylvania transferred in excess of $200 Million Dollars from the reserve of the State Workmens Insurance Fund to fund general obligations of the state. *See Scranton Times*, March 10, 1988 "State Fund—Transfer Fund is Both Criticized, Praised." (Appendix 2a).

SWIF is considered the insurer of last resort because it is required by law to write policies for employers that cannot obtain coverage on the open market. (Appendix 3a). Private insurance companies derive a direct benefit by the existence of SWIF. Indeed, the petitioners insurers have sought to raise issues on behalf of SWIF in this case because of the financial interdependence of SWIF and private insurers in the integrated Pennsylvania Workers' Compensation system. (See Petitioners Brief pg. 30, n.15). Private insurers such as Petitioners can avoid writing high risk employers because SWIF is available to provide state mandated workers compensation coverage, as insurer of last resort.

The Pennsylvania legislature has in the past commingled SWIF and other state funds. (*See* Footnote 4, e.g. Act 1988-56A. October 14, 1988, App. 1A, 2A, 9A). SWIF has been adjudicated to be a state actor whether insuring public or private employers. *Baksalary v. Smith*, 579 F. Supp. at 230. *See also Rumpf v. SWIF*, 964 F. Supp. 180, 186 (E.D. Pa. 1997).

As partial justification for denying disabled workers predeprivation notice and opportunity to be heard under the circumstances of this case, the Respondent School District of Philadelphia and Petitioner insurers assert that in 1993 SWIF was on the verge of bankruptcy, and was actuarially unsound because of rising medical costs. (*See* Petitioner insurers School District Brief, pg. 3 and Petitioner Insurers Brief, pg. 1). These assertions are not actuarially substantiated by the parties herein. Further, neither party mentions in their briefs that in 1988 and 1989 the Pennsylvania legislative and executive branches raided the SWIF reserve fund of substantially more than $200 Million Dollars of subscriber premiums to pay general fund obligations. *See* e.g. Act 1988-56A, October 14, 1988, Appendix Exhibit 1A, *Scranton Times*, March 10, 1988 "State Fund-Transfer Fund is Both Criticized and Praised" *Scranton Times*, February 10, 1988, "Reallocation Plan Gets SWIF Board Nod". App. 9A.

Also, in 1992, prior to the enactment of the Act 44 of 1993, the Commonwealth was reported to have transferred well in excess of $17 million dollars from the SWIF surplus to purchase two failing southeastern Pennsylvania financial institutions, Tobias Knoblauch Private Bank of Reading and Marian Bank of Philadelphia. The Reading Eagle—April 18, 1993, App. 17a-18a. Apparently, less than half of the money was repaid without interest. After nearly failing, the formerly private Banks were re-opened in April, 1992, as Knoblauch State Bank and Marian State Bank. On April 20, 1992, it was reported that "The re-opened banks are owned by the State Workmen's Insurance Fund, which can provide capital to keep them in operation." App. Ex. 11A. *The Scranton Times*, Monday, April 20, 1992. *See also* App. Ex. 11A *The Reading Eagle, Dead Bank's Ghost Haunts Courts*, App. 12A; *The Reading Eagle*, April 18, 1993, *"Will Banks Success or Succeed?" See Knoll et al. v. Butler, et al., — Pa. Cmwlth —*, 675 A.2d 1308, 1310 (1996), aff'd, 548 Pa. 12, 693 A.2d 198 (1997). On September 14, 1994 Marian State Bank merged into Knoblauch State Bank (KSB) leaving KSB the sole entity, wholly owned by the State Workmen's Insurance Board which administers S.W.I.F. *Knoll v. Butler*, supra 675 A.2d at 1310 n.4. On January 10, 1995, S.W.I.B. resolved to sell all shares of KSB to Royal Bank for $8,543,850. *Knoll v. Butler*, 675 A.2d at 1510.

Indeed, SWIF has acknowledged in an affidavit filed with the Federal District Court for the Eastern District of Pennsylvania that the Pennsylvania legislature has authorized the commingling of SWIF funds with other state funds. *Rumpf v. State Workmen's Insurance Fund*, 964 F. Supp. 180, 186 (E.D. Pa. 1997). Thus, the financial condition of SWIF and its causes are considerably more complex than acknowledged by the Petitioners insurers and Respondent Philadelphia School District.

The Pennsylvania Supreme Court has explained that worker's compensation benefits are statutory public benefits rather than insurance benefits:

> "The payments an injured employee receives are not themselves insurance benefits, they are an obligation imposed by statute on the employer. When an employer obtains insurance to secure the risk that it will make such payments, it guarantees a source of the payment of such benefits, but this does not change the nature of the payments due the employee."

Hankee v. Wilkes-Barre Scranton International Airport, supra, 616 A.2d at 619. The right to continued enjoyment of these public benefits are a property right. *Baksalary v. Smith*, supra.

Amendment to Section 355 of the Act in 1966, 77 P.S. § 501 inserted the second sentence which requires the insurer to assume the employer's liability, and entitled the insurer to all of the employer's immunities and protections. *See* 77 P.S. § 501 [Historical and Statutory Notes]; *Jadosh v. Goeringer*, 442 Pa. 451, 275 A.2d 58 (1973). This, however, does not change the statutory nature of the obligations of the employer. *See Hankee*, supra. In *Brown v. Travelers Insurance Company*, 434 Pa. 507, 514, 254 A.2d 27, 29 (1969), a case decided before the Act was amended to specifically so provide, the Pennsylvania Supreme Court held that an employer's insurance carrier is immune from the suit as is the employer, a holding the Court found necessary to avoid "a regrettable discrimination . . . between employers who are insured by the State Workers' Insurance Fund or are self-insuring employers and those who carry private insurance." *Id.* at 514, 254 A.2d at 29. *See also, Keller v. Old Lycoming Twp.*, 286 Pa. Super. 339, 428 A.2d 1358, 1364-1365 (1981) (Court noted incongruity of treating workers differently simply because of the status of the payor of their workers compensation insurance.)

The Commonwealth expressly assumes the obligation of the insurance companies, if and when, an insurer becomes insolvent. 77 P.S. §§ 1053, 1055. *Sullivan v. Barnett*, 739 F.3d 158, 169 (3d Cir. 1998).

Prior to Act 44 of 1993, only a "referee" or "workers compensation judge" was authorized to make a determination that medical treatment and expenses were unreasonable or unnecessary and/or suspend benefits. As a result of the exclusive nature of the remedy under the Act, an injured employee has no practical remedy whatsoever to obtain reimbursement for medical treatment for work-related injuries outside the Act. The suspension of medical benefits and the determination of the necessity of treatment of concededly work related injuries clearly "involves the performance of a traditional function of the government." *Edmonson v. Leesville Concrete Co.*, 500 U.S. 614, 624, (1991).[5] *Mark v. Borough of Hatboro*, 51 F.3d 1137, 1157 (3d Cir. 1995) reh. den. 116 S.Ct. 165. As previously stated, the Pennsylvania Supreme Court has stated that compensation cases "are essentially of a judicial character". *Shortz v. Farrell*, 327 Pa. at 87, 193 A. at 22.

Act 44 of 1993 now initially delegates the governmental function of suspending benefits and thereafter determining reasonableness and necessity of treatment for presumptively work related conditions to insurers and utilization review organizations. 77 P.S. § 531(6)(i) (1993). The challenged utilization review provisions, 77 P.S. § 531(5) and (6), fail to provide any predeprivation notice or opportunity to be heard before medical benefits are suspended, superseded, or tolled. *Sullivan v. Barnett*, 139 F.3d at 172-173.

In the context of the Pennsylvania statute, an employers' or insurers' suspension, with state approval, of a workers medical benefits and uninterrupted access to treatment without any pre-deprivation safeguards, clearly

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[5] Prior to *Edmonson v. Leesville Concrete Co.*, supra, it has been stated that in order to constitute state action under [the public function] doctrine, private conduct must not only comprise something the government traditionally does, but something *only* the government traditionally does. *See Mark v. Borough of Hatboro*, 51 F.3d at 1157.

involves acting under color of state law. This statute delegates to employers and insurers the power to suspend a vested state entitlement to reasonable and necessary medical treatment when needed. In so doing, Petitioner insurers act to promote the Commonwealth encouraged statutory policy of cost containment at the expense of the procedural due process rights of concededly disabled workers to reasonable and necessary medical benefits as and when needed. Both the Petitioners American Manufacturers Mutual et al. (*see* pages 2-3) and the Respondent School District of Philadelphia (*see* pages 1-4) admit, in their briefs that the Commonwealth of Pennsylvania profits by the actions of the employers and insurers invoking utilization review without providing predeprivation notice and opportunity to be heard. The state's fiscal interest in a discriminatory action is "relevant" to a finding of state action in the total context of the subject circumstances. *Burton v. Wilmington Parking Authority,* 365 U.S. 715 (1961); *Edmonson v. Leesgeld Concrete Co.,* supra. *See also Tulsa Professional Collection Services, Inc. v. Pope,* 485 U.S. 478 (1988); *West v. Atkins,* supra. The interpretation of the *Burton* decision by the U.S. Supreme Court in *Rendall-Baker v. Kohn,* 457 U.S. 830, 843-844 (1982) is instructive and demonstrates that state action should be found in the context of this case. The majority in *Rendall-Baker* reasoned:

> "In *Burton,* the Court held that the refusal of a restaurant located in a public parking garage to serve black Americans constituted state action. The Court stressed that the restaurant was located on public property and that the rent from the restaurant contributed to the support of the garage. 365 U.S., at 723, 81 S. Ct. at 860. In response to the argument that the restaurant's profits, and hence the State's financial position, would suffer if it did not discriminate, the Court concluded that this showed that the *State profited* from the restaurant's discriminatory conduct. The Court viewed this as support for the conclusion that the State should be charged with the discriminatory actions."

Rendall-Baker v. Kohn, 457 U.S. at 843-44 (discussing significance of *Burton*).

To justify the lack of predeprivation notice and opportunity to be heard, the insurers cite the need for cost containment in the state system. SWIF, and the Commonwealth of Pennsylvania, directly benefit by the constitutional deprivations resulting from the utilization review procedure. This clearly is a significant and "relevant" factor. In *Edmonson v. Leesville Concrete Co.,* 500 U.S. at 622, this Court weighed "relevant" factors in making the state action determination rather than establishing an unrealistic litmus test. 500 U.S. at 622. Leaving flexibility in this area is clearly appropriate. The framers of the Constitution could not forsee telecommunications or computers, yet the Constitution continues to have application in these fields.

The Third Circuit Court of Appeals, in the decision below, concluded that:

> "The benefits provided to employees under the Act are a constitutionally protected entitlement. None of the parties disputes this. The Commonwealth has created this entitlement, and the Commonwealth guarantees that this benefits will be paid to an injured employee."
>
> * * * *
>
> "Although the insurance companies are private entities, when they act under the construct of the Workers' Compensation system, they are providing public benefits which honor state entitlement. In effect they become an arm of the State, fulfilling the uniquely government obligation under an entirely state oriented, self contained public benef system. It is a system which the government alone administers" *Edmonson,* 500 U.S. at 622, 111 S. Ct. at 2083-84. Thus, we conclude the insurance companies are a partner or an arm of the State in implementing legislation that administers constitutionally protected entitlement which the Commonwealth has enacted as a matter of policy.

> The right to invoke the supersedeas, or to stop payments, is a power that traditionally was held in the hands of the State. When insurance companies invoke the supersedeas (i.e., suspension) of an employee's medical benefits, they compromise an employee's State-created entitlement. The insurers have no power to deprive or terminate such benefits without the permission and participation of the Commonwealth. More importantly, however, the Commonwealth is intimately involved in any decision by an insurer to terminate an employee's constitutionally protected benefits because an insurer cannot suspend medical payments without first obtaining authorization from the Bureau. However, this authorization may be characterized, any deprivation that occurs is predicated upon the State's involvement."

193 F.2d at 168.

The decision of the Third Circuit below is consistent with Pennsylvania case law. In *Keller v. Old Lycoming Township*, 286 Pa. Super. at 348 n.6, 428 A.2d at 1363 n.6 (1981), the Pennsylvania Superior Court analogized this public benefit as being equivalent to a "soldier's right to a pension." *Id.*

The purpose of the Pennsylvania Workmen's Compensation Act is to provide the sole and exclusive means of recovery for all injuries within its scope. *See Socha v. Metz*, 385 Pa. 632, 123 A.2d 837, 839 (1956); *Povser v. Newman & Co., Inc.*, 514 Pa. 32, 522 A.2d 548, 550-551 (1987). "[T]he injured employee has no other right of action. By virtue of the Compensation Act, an employee's common law right to damages for injuries suffered in the course of his employment as a result of his employer's negligence is completely surrendered in exchange for the exclusive statutory right of the employee to compensation for all injuries, regardless of negligence, and the employer's liability as a tortfeasor under the law of negligence of injuries to his employee is abrogated." *Socha v. Metz*, 123 A.2d at 839-840. "[W]hile this employer assumes liability without fault for a work-related injury, he is relieved of the possibility of a larger damage verdict in a common law action." *Kuney v. PMA Insurance Co.*, 525 Pa. 171, 578 A.2d 1285, 1286 (1990); *Keller v. Old Lycoming Twp.*, 286 Pa. Super. 339, 428 A.2d 1358, 1363 (1984); ("[T]he amount of recovery, however, is below that which [the injured worker] might expect if he could obtain an award of damages at common law.").

The system is mandatory. An employee cannot opt out of the Pennsylvania Workers' Compensation scheme in favor of their own privately obtained coverage. (See 77 Pa. Stat. Ann. § 461, Historical notes); *Baksalary v. Smith*, 579 F. Supp. 218, 231 n.19 (E.D. Pa. 1984), aff'd 772 F.2d 893 (3rd Cir. 1988), cert. denied 469 U.S. 1145 (1985). A worker cannot bargain away statutorily prescribed workers compensation coverage. Historically, neither the employee, employer or insurer could enter a contract permitting payments contrary to the Act or varying the amount to be paid, or the period during which compensation is payable as provided in the Act. Such illegal agreements are "wholly null and void." Section 407, 77 P.S. § 731 (1972); *Rollins Outdoor Advertising v. W.C.A.B., (Maas)*, 506 Pa. 592, 487 A.2d 794 (1985); *Reilly v. W.C.A.B. (General Electric Co.)*, 98 Pa. Cmwlth. 488, 512 A.2d 749 (1986) app. den. *Petition of General Electric Co.*, 514 Pa. 650, 524 A.2d 495, app. den. 514 Pa. 651, 524 A.2d 496, app. after rem. 136 Pa. Cmwlth. 543, 584 A.2d 304.

In *Hankee v. Wilkes-Barre, Scranton International Airport*, 532 Pa. 494, 616 A.2d 614 (1992), the Pennsylvania Supreme Court *adopted the argument of workers' compensation carriers*, Aetna and Liberty Mutual, and the party employers, in ruling that workers compensation benefits do not constitute "insurance policy benefits". The Pennsylvania Supreme Court concluded that local government political subdivisions and their carriers had a right to subrogation of tort recoveries against third party tortfeasors whose negligence caused the worker's injuries. Accord,

Winterberg v. Transp. Ins. Co., 72 F.3d 318, 325 n.4 (3rd. Cir. 1998) (A workman's compensation claim is not based on an insurance policy within the meaning of [42 Pa. C.S.A. § 8371]. The claim is statutory and has its genesis in the contract of hire between the employer and employee (*see* 77 Pa. C.S.A. § 431), not an insurance contract. The employer's obligation to pay for a compensable injury is not predicated on an insurance policy.")

In *Hankee*, supra, the Pennsylvania Supreme Court explained the nature of this statutory benefit system for workers in Pennsylvania:

> "As the appellees note, the Workmen's Compensation Act does not define the compensation received by injured employees as insurance, and several cases have observed, in broad context, that the Act does not render employers insurers of the life and health of their employees. See, e.g., *Monahan v. Seeds & Durham*, 336 Pa. 67, 6 A.2d 889 (1939). Rather, it has been recognized from the outset that the Act is remedial social legislation, which substitutes a relatively quick and inexpensive scheme to provide certain compensation for lost earnings, in place of the common law process under which any damages would be recoverable only after a suit against the appropriate parties, subject to available defenses and, of course, any expenses and delays inherent in the system. Under the scheme, employees are able to obtain compensation without regard to fault—either their own, that of a third party, or even the lack of fault on the part of the employer—while employers are subject to payment of benefits at a set rate, receive immunity from being otherwise subjected to liability for damages, and have a right of subrogation to the extent of compensation paid in the event a third party is held responsible for the injury. Although an employer may secure its obligation to pay compensation by contracting with an insurer, and an injured employee may receive payments directly from the insurance carrier, in determining the nature of the benefits it cannot be ignored that the employer is obligated to provide the compensation without regard to the obtaining of insurance, and if insurance is obtained it is the employer, not the employee, that is the insured."

Id. at ——, 616 A.2d at 617.

The Pennsylvania Supreme Court further explained:

> "The payments an injured employee receives are not themselves insurance benefits, they are an obligation imposed by statute on the employers when an employer obtains insurance to secure the risk that it will have to make such payments, it guarantees a source for the payment of such benefits, but this does not change the nature of the payments due the employee."

Id. supra, at ——, 616 A.2d at 619.

Conceptually, the Pennsylvania Workmen's Compensation Act, as originally enacted, arose out of the contract of hire between the employer and employee. In *Swartz v. Conradis*, 298 Pa. 343, 346, 148 A. 529, 530, (1929), the Pennsylvania Supreme Court explained:

> "When the statutory employer accepts article III [of the Compensation Act] he is relieved of all liability for compensation at common law. Section 303 * * * makes the 'agreement [referred to in section 302] * * * operate as a surrender by the parties thereto of their rights to any form or amount of compensation. * * * or to any method of determination thereof, other than as provided in article III of this act.' "

Id. at 346, 148 A. at 530.

In *Socha v. Metz*, 385 Pa. 632, 123 A.2d 837, 840 (1956), the Pennsylvania Supreme Court further explained the nature of the contract concept.

> "There is a conclusive presumption under the Workers Compensation Act of Pennsylvania that the par-

> ties to every contract of hiring agree to be bound by the Act unless at the time of making, renewal or extension of such contract one or the other of the parties, by express statement in writing rejects the provisions of the Act and the burden of proving that the Act is not applicable is upon the party so asserting."

Socha v. Metz, 123 A.2d at 840.

The contract concept was legislatively eliminated however in Act 263 of 1974, effective February 3, 1975 amended Section 302(a), 77 P.S. § 461 by deleting the rejection option. This amendment made the Workers Compensation Act and Occupational Disease Act, 77 P.S. § 1201 et seq., mandatory without any opt out provision. *Bible v. Com. Dept. of Labor and Industry*, 548 Pa. 247, 696 A.2d 1149, 1153 (1997); *Barber v. Pittsburgh Corning Co.*, 531 Pa. 29, 555 A.2d 766, 769 (1989). In *Bible*, the Pennsylvania Supreme Court stated:

> In 1974, Section 301(a) was amended to provide that, 'Every employer shall be liable for compensation for personal injury to, or the death of each employee, by an injury in the course of his employment. . . .' The references to agreements between employer and employee, either express or implied, and presumptions with regard to acceptance of the Act, were eliminated. The workers' compensation system as it is now structured is purely an exercise of the "police power" of the Commonwealth regulating the employer-employee relationship. As a result, there is no longer any basis for construing the provisions of the Workers' Compensation Act in contractual terms."

Id. at ——, 696 A.2d at 1153.

The petitioners, American Manufacturers Mutual Insurance Company, et al. completely ignore the effect of the 1974 amendments. Moreover, Petitioner's cite a pre-1974 amendment case, *Silas v. Smith*, 361 F. Supp. 1187 (E.D. Pa. 1993), for the proposition that:

> "[W]hat is here involved is a contractual although sanctioned by statute claim to benefits which the other party to the contract disputes." (See Petitioner's, American Mutual Insurance Co., Brief p. 20).

In *Baksalary v. Smith*, 579 F. Supp. at 231 n.19 (E.D. Pa. 1984), the three Judge panel for the Federal District Court for the Eastern District of Pennsylvania stated:

> "Since the decision in *Silas*, Pennsylvania has amended the Workmen's Compensation Act to make it mandatory. . . . We believe that the change in the coverage of the Act from optional to mandatory eliminates *Silas'* analogy of Section 413's automatic supersedeas to the operation of any ordinary commercial contract. The mandatory quality of the Act now makes every aspect of the compensation schemes operation appear more 'public' and less 'private'."

Id. at 231 n.19.

Similarly, the brief of the Amici Curiae American Insurance Association, et al. misconstrues the nature of the statutory relationship between employer/employee as being a private contractual relationship. Their brief states:

> "The statute merely authorizes insurers to invoke a 'self-help' remedy inherent in any private contractual relationship—a refusal to provide contractual benefits pending resolution of a dispute about the scope of the contractual obligation." (p.4) . . . The relationship between insurer, insured employer, employee and medical care provider is thus a voluntary contractual one, albeit one extensively regulated by the state." (p.6)

As the Historical Notes to 77 P.S. § 431 and the *Hankee*, *Bible*, *Winterberg* and *Baksalary* cases demonstrate, contract analysis has had no place in interpretation of the Pennsylvania Workmen's Compensation Act for nearly twenty-five years since the 1974 amendments to the Act.

The exclusive nature of this public benefit system, which is an incident of employment in Pennsylvania, has

been reaffirmed in a myriad of decisions and circumstances by the Pennsylvania appellate courts and federal courts interpreting the Act. *See* e.g. *Kline v. Arden H. Verner, Co.*, 503 Pa. 251, 256, 469 A.2d 158, 160 (1983), (a tort action for any work-related injury was barred.); *Poyser v. Newman & Co., Inc.*, 514 Pa. 32, 522 A.2d 548, 550 (1987), (Act is "a version of the historical *quid pro quo* the employers received in return for being subjected to a statutory, no-fault system of compensation for worker injuries. An employer is immune for intentional misconduct and deliberate disregard for employees' safety."); *Barber v. Pittsburgh Corning Co.*, 521 Pa. 29, 555 A.2d 772 (1989) (Employer immune under Occupational Disease Act from tort action for deliberate or reckless conduct injuring employee.), *Kuney v. PMA*, 525 Pa. 171, 578 A.2d 1285 (1990) (a workers compensation insurer is conferred immunity coextensive as its insured); *LeFlar v. Gulf Creek Indus. Park No. 2*, 511 Pa. 574, 515 A.2d 875, 879 (1986) (Act deprives the common pleas courts of jurisdiction of common law tort actions for negligence against employers.); *Rosipal v. Montgomery Ward*, 360 Pa. Super. 570, 521 A.2d 49 (1987), allocator granted, 516 Pa. 635, 533 A.2d 93 (1987), app. dis., 517 Pa. 460, 538 A.2d 495 (1989) (An employer cannot be sued in tort for alleged bad faith filing of a termination petition where it was alleged that the employer filed a fraudulent and perjured affidavit.). *See also Winterberg v. Transp. Ins. Co.*, 72 F.3d 318, 325 n.4 (3rd Cir. 1998) (An insurer cannot be sued under the Pennsylvania "bad faith" insurance statute, 42 Pa. C.S.A. § 8371 and the Unfair Trade Practices and Consumer Protection Law, 73 Pa. S. § 201-1 et seq.)

The Pennsylvania Supreme Court has recognized that the Pennsylvania Act was unique and differed from other states workers compensation Acts. In *Poyser v. Newman & Co., Inc.*, supra, then Justice, later Chief Justice Robert N.C. Nix Jr. writing for the Pennsylvania Supreme Court stated:

> "It is true that the appellate courts of some other states have held that wanton and willful misconduct by an employer is tantamount to an intentional tort, and as such, prevents the operation of a statutory exclusive-remedy provision. See, *e.g., Mandolidis v. Elkins Industries, Inc.*, 161 W.Va. 695, 246 S.E.2d 907 (1978). It must be noted, however, that those cases rested on provisions in the state workmen's compensation statutes which expressly preserved their right of an employee to sue in tort where his injury was caused by the employer's intentional wrongdoing. There is no such provision in The Pennsylvania Workmen's Compensation Act."

Id. at 37-38, 522 A.2d at 557.

Prior to Act 44 of 1993, all decisions regarding contests regarding reasonableness or necessity of all treatment provided by a health care provider to injured workers was subject to the exclusive jurisdiction of workers compensation "referees", now known as workers compensation judges. *See* 77 P.S. § 531(2)(ii) (1978) and 77 P.S. § 701-717 (1978). Workers compensation judges were under the supervisory jurisdiction of the Secretary of the Department of Labor and Industry. 77 P.S. § 701.

Prior to Act 44, the employer had the right to petition the Department for review of the necessity or frequency of treatment or reasonableness of fees for services provided by a physician or other duly licensed practitioner of the healing arts. 77 P.S. § 531 (1978). Prior to Act 44 of 1993, 77 P.S. § 531(2)(ii) specifically provided that the filing of a Petition to Review the reasonableness or necessity of medical treatment "shall in no event act as a *supersedeas*, and during the pendency of any such petition the employer shall pay all bills if the physician or other practitioner of the healing arts files a report or reports as required . . ." (emphasis added)

After the enactment of Act 44, all contests initiated by the insurance carrier, or employer, as to the reasonableness or necessity of all medical treatment provided to a

worker was required to be submitted to a utilization review organization authorized to make utilization review by the Department of Labor and Industry. 77 P.S. § 531(6)(i) (1993). 77 P.S. § 531(6)(f) provides that the department shall authorize utilization review organizations to perform utilization review under the Act. "Organizations not authorized by the department may not engage in such utilization review." Section 77 P.S. § 531(6)(i).

Once an employer, or insurer, disputes the reasonableness or necessity of treatment provided to an injured worker *and the Bureau approves the filing* (*see Tulsa Professional Collection Services v. Pope*, 488 U.S. at 486-87), the employer or insurer has no obligation to pay for the medical treatment. 77 P.S. § 531(5) (1993). The employer's obligation to pay is "tolled". 34 Pa. Code §§ 127.208(e)(f), 127.403. Under prior statutes, the suspension of the employer's obligation was termed a "supersedeas". *See* 77 P.S. § 531(2)(ii) (1978). Apparently, the drafters of the Act 44 of 1993 automatic suspension, or supersedeas provisions believed that the effect of *Baksalary v. Smith supra*, prohibiting prehearing deprivation of benefits, could be circumvented if the obligation to pay ongoing benefits was interrupted by what is termed a "tolling" rather than a "supersedeas". This suggests an attempt to elevate form over the substance in this situation. In practical terms, the "tolling" under the utilization review procedures of Act 44 of 1993 constitutes what was formerly known as "supersedeas" or suspension if the Department of Labor and Industry, Bureau of Workers Compensation approves the filing requesting utilization review by the insurer/employer.

Under Act 44 as originally drafted, all an insurance carrier need to do in order to suspend, toll or supersede its obligation to pay for ongoing medical benefits "as and when needed" by an injured worker, is to file a request *for utilization review for all past and future medical treatment*, subject to the approval of the Bureau. See 77 P.S. § 531(5) and (6). In present practice, insurers routinely

request review for all present and future treatment and medical expenses.

These disabled workers have a legitimate claim of entitlement to ongoing medical services for that work-related disability because they are already adjudicated as having work related injuries. *Baksalary v. Smith*, 579 F. Supp. at 225 (1984) (finding that a person already receiving workers' compensation benefits has a property interest in the continued receipt of such benefits.) Act 44 utilization review defeats the right to uninterrupted benefits without giving the injured worker any predeprivation notice or opportunity to explain how the questioned treatment impacts on his or her life. *Sullivan v. Barnett*, 139 F.3d at 175-177. The Third Circuit has explained:

> "[A] particular treatment might be the only medical treatment that alleviates an individual's pain or mitigates the severity of his or her symptoms. As the utilization review process concerns itself only with the specific medical practice that is being challenged, *see* 34 Pa. Code § 127.490, the reviewing physician may have little or no perspective as to how a particular treatment is benefitting the patent in the context of the overall medical care that the employee has undergone during the course of his/her disability. The opportunity for the employee to present his/her side of the story—to introduce his/her own personal account as to how the particular treatment has ameliorated his/her condition—may be highly relevant to the URO's determination and may not be adequately reflected or documented in the medical reports."

Sullivan v. Barnett, at 177.

Act 44 of 1993 does not provide for an immediate hearing for acute care service denials, particularly where delivery of service is prevented by a denial. In *"Cost as a Barrier to Medical Care in Relation to Unemployment Rates"*, the authors, physicians and researchers from the Center for Disease Control and Prevention in Atlanta recently wrote:

> "To the Editor: There is a strong evidence that people who receive medical treatment in a timely manner have improved health outcomes. Thus, delays in seeking medical care because of concern about cost can have serious effects. This consideration was prominent in the debate on health care reform in the early 1990's but received much less publicity once the national effort to reform health care failed."

The New England Journal of Medicine, Nelson et al., *"Cost as a Barrier to Medical Care in Relation to Unemployment Rates"*, Vol. 339, No. 22, pg. 1644-1645 (November 26, 1998) (Appendix Exhibit 4A-6A).

In this sense, denial of access to timely medical care constitutes a "uniquely final deprivation which a retroactive mandatory award can never remedy." *See Memphis Light, Gas & Water Division v. Craft*, 436 U.S. 862 (1978) (referring to the time plaintiff's spend without access to utilities, enduring cold, darkness and lack of water, which cannot be remedied by or after the fact damage award.)

Moreover, most, if not all private medical insurance contracts, contain exclusions for payment of medical expenses for conditions which are causally related to an injury suffered in the course and scope of employment. For instance, the agreement between Blue Cross/Blue Shield of Northeastern Pennsylvania and employer's provides an exclusion for illness or injury that is subject to workers compensation coverage. (*See, e.g.*, Appendix Exhibit 7A-8A).

Thus, the practical effect of the filing of a request for utilization review, which must be approved by the State, is to restrict an admittedly disabled worker's access to care during the pendency of the review process. Even if an employee has alternative coverage, the work-related injury exclusions will result in denial of authorization for care and resulting restriction of access to reasonable health

care. This will have grave consequences for the worker because it may mean that the worker will go without medical necessary service, including making prescriptions available for relief of pain. Given the many months or even years that it takes for appeal of utilization review determinations, deprivations without notice or opportunity to be heard will have significant impact on the quality of life of disabled workers and may even be life-threatening. Subsequent due process comes too late in many cases. *Memphis Light, Gas & Water Division v. Craft*, supra.

The Third Circuit properly recognized that:

> "We are also aware that the government has an interest in not wrongfully depriving medical benefits to disabled individuals and ensuring that employees who reasonably and legitimately need medical care under the Act will continue to receive it."

139 F.3d at 176.

Finally, in the Reply Brief for Petitioners in support of their Petition for Certiorari, the insurers state that:

> "[T]he real targets of utilization review are not the injured workers, but unscrupulous medical care providers who provide unnecessary and unreasonable service to workers."

(*See* American Manufacturers Mutual Insurance Company, et al. Reply Brief for Petition for Writ of Certiorari 9). If this is the case, why doesn't the Pennsylvania legislature address the real target of utilization review, and stop denying procedural due process to legitimately entitled workers who suffer the misfortune of disabling injury through no fault of their own. Perhaps, the insurance companies can recoup their monies from those so-called "unscrupulous physicians" by employing the Pennsylvania Medical Practice Act of 1985 and the American Medical Association Code of Ethics, the hollow remedy that the Petition insurers offer injured workers to protect their right to uninterrupted medical care as and when needed.

CONCLUSION

In the unique context of the Pennsylvania Worker's Compensation system, Amici submit that the decision of the Third Circuit Court of Appeals below should be affirmed, as an appropriate exercise of the authority of the federal courts to guarantee rights to procedural due process of law guaranteed by the United States Constitution. *Marbury v. Madison*, 5 U.S. (1 Cranch) 137, 177-178 (1803)). "[T]he very essence of judicial duty," is to determine whether a legislative act is repugnant to the Constitution and is therefore "void." *Marbury v. Madison*, 5 U.S. at 177-178. In *The Federalist*, No. 78, by Alexander Hamilton, he reasoned

> There is no position which depends on clearer principles than that every act of a delegated authority, contrary to the tenor of the commission under which it is exercised, is void. No legislative act, therefore, contrary to the Constitution, can be valid.
>
> * * * *
>
> A constitution is, in fact, and must be regarded by the judges as, a fundamental law. . . . . [The judges] ought to regulate their decisions by the fundamental laws rather than by those which are not fundamental.

The Federalist, No. 78, Hamilton (1787-1788).

Amici respectfully submit that this is precisely what the Third Circuit did below in determining that suspending payment of medical compensation without affording disabled workers any predeprivation notice or opportunity to be heard violated the Fourteenth Amendment of the United States Constitution.

Respectfully submitted,

MARK S. MANDELL
President of
The Association of Trial Lawyers of America
JEFFREY WHITE
Associate General Counsel
Office of General Counsel
of The Association of Trial Lawyers of America
1050 31st Street, N.W.
Washington, D.C. 20007
(202) 965-7500
Counsel for Amici Curiae, The Asssociation of Trial Lawyers of America

RICHARD A. KIMNACH
ANESI, OZMON, RODIN,
NOVAK & KOHEN, LTD.
Suite 2100 21st floor
161 N. Clark
Chicago, Illinois 60601
Counsel for Amici Curiae The Workplace Injury Litigation Group, Inc.

MICHAEL J. FOLEY
Counsel of Record
FOLEY, MCLANE, FOLEY,
MCDONALD & MACGREGOR
Linden Plaza, 600 Linden Street
P.O. Box 1108
Scranton, Pennsylvania 18501-1108
(717) 342-8194
Counsel for Amici Curiae, The Pennsylvania Trial Lawyers Association, The Association of Trial Lawyers of America, and The Workplace Injury Litigation Group, Inc.

APPENDIX

APPENDIX

SESSION OF 1988

No. 1988-56A

AN ACT

HB 2414

Appropriating and transferring amounts from the State Workmen's Insurance Fund to the Treasury Department and the General Fund.

The General Assembly of the Commonwealth of Pennsylvania hereby enacts as follows:

Section 1. The following sums, or as much thereof as may be necessary, are hereby appropriated from the State Workmen's Insurance Fund for the fiscal year beginning July 1, 1988:

(1) The sum of $25,000,000 is appropriated to the Treasury Deprtment for transfer to the Sunny Day Fund.

(2) The sum of $25,000,000 is appropriated to the Treasury Department for transfer to the Tax Stabilization Reserve Fund.

Section 2. The sum of $60,000,000 is hereby transferred from the State Workmen's Insurance Fund to the General Fund.

Section 3. This act shall take effect immediately.

APPROVED—The 14th day of October, A. D. 1988.

ROBERT P. CASEY

The Scranton Times—March 10, 1988

STATE FUND-TRANSFER PLAN IS BOTH CRITICIZED, PRAISED

Associated Press

HARRISBURG—A Casey administration plan to dip into a state insurance fund to provide aid for mass transit and other programs has been criticized by some lawmakers, but state officials say the move is "wise and defensible."

The proposed transfer, which would shift about $220 million from the State Workman's Insurance Fund, was proposed by Casey last month.

During legislative budget hearings Wednesday, administration officials were badgered about the plan, which must be approved by the Legislature.

Some lawmakers have said the transfer, including $25 million for mass transit, is unconstitutional.

Michael Hershock, the state budget secretary, told members of the Senate Appropriations Committee the transfer had been reviewed by the governor's legal staff and was feasible.

"We stand behind our request. We think it is a wise and defensible one," he said.

Transportation Secretary Howard Yerusalim told members of the House Appropriations Committee that although lawmakers may not go along with the SWIF transfer, that administration officials would "not turn our back on mass transit."

Yerusalim said Casey was committed to a 4 percent boost for mass transit. In a later interview, Yerusalim said there was no contingency plan to replace the $25 million if the SWIF transfer is not approved. However, he said he was confident mass transit would get the SWIF funds.

SWIF is a worker compensation insurance program for the state and other employees who can't get insurance on the open market. One administration official has described SWIF as an "embarrassment of riches," which has expanded rapidly through prudent investments.

Hershock told the committee if SWIF funds are not included in the budget, the funds needed for those programs "will come from somewhere else."

In other issues discussed Wednesday during budget hearings, testimony submitted to the House committee by Revenue Secretary Barton Fields indicated sales of lottery tickets are expected to increase about 6 percent over 1986-87 levels by the close of the fiscal year. Sales were initially projected to show a 3 percent increase.

However, Fields warned that the lottery fund will go into deficit by 1989-90 unless continued cost-cutting steps and other measures are taken.

"Lottery-funded program costs are still increasing at a rate significantly faster than the rate of sales growth," he said.

On college funding, Hershock defended the administration's proposed 4 percent increase for higher education. Senate Republicans have suggested a 10 percent increase.

Hershock said state-owned and state-related universities across the state sought increases of between 16 percent and 31 percent for fiscal 1988-89.

"There's no way short of a tax increase we could meet those kinds of requests," he said.

The New England Journal of Medicine—
November 26, 1988

COST AS A BARRIER TO MEDICAL CARE IN RELATION TO UNEMPLOYMENT RATES

To the Editor: There is strong evidence that people who receive medical treatment in a timely manner have improved health outcomes.[1-2] Thus, delays in seeking medical care because of concern about cost can have serious effects. This consideration was prominent in the debate on health care reform in the early 1990s but received much less publicity once the national effort to reform health care failed.

We examined trends in the perception that cost is a barrier to medical care. Data from 1991 through 1996

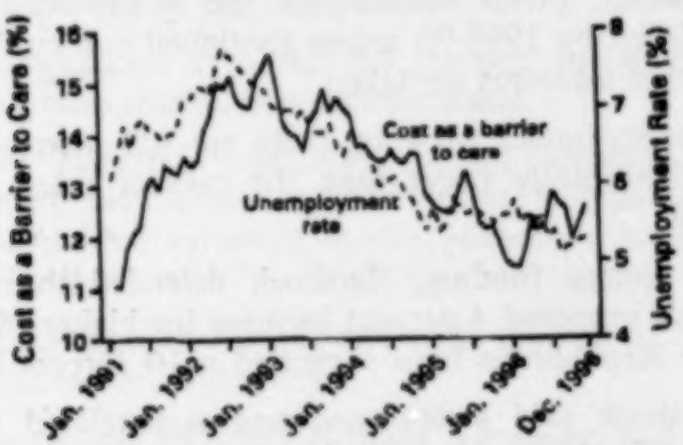

Figure 1. Prevalence of the Perception That Cost Was a Barrier to Medical Care, According to the Unemployment Rate, from January 1991 through December 1996.

[1] The Hypertension Detection and Follow-up Program Cooperative Group. Persistence of reduction in blood pressure and mortality of participants in the Hypertension Detection and Follow-up Program. JAMA 1988;259:2113-22.

[2] The Lipid Research Clinics Coronary Primary Prevention Trial results. I. Reduction in incidence of coronary heart disease. JAMA 1984;251:351-64.

were obtained from the 45 states (all but Arkansas, Kansas, Nevada, Rhode Island, and Wyoming) that participated in the Behavioral Risk Factor Surveillance System in each of these years.[3] Monthly telephone surveys of randomly selected adults were conducted in each state; the median annual rates of response ranged from 77.8 to 84.2 percent. Data were weighted according to each state's population and pooled, resulting in monthly sample sizes ranging from 5756 to 7947 respondents. Our analysis of the perception that cost was a barrier to medical care was based on the response to the following question: "Was there a time during the last 12 months when you needed to see a doctor, but could not because of the cost?" We used a time-series approach to analyze these data for all months and then compared our findings with monthly unemployment rates during the same period.

The prevalence of the perception that cost was a barrier to medical care increased from 11 percent to 15 percent from January 1991 to January 1993 but then declined nearly to the 1991 value by late 1996 (Fig. 1). Comparisons of monthly unemployment rates and the prevalence of the perception that cost was a barrier to care showed a slight difference between the two during the first nine months of 1991, with the patterns of the two variables then becoming similar for the rest of the study.

Although other factors (e.g., increased enrollment in managed care and extensive media coverage of health care reform efforts) may have had a role,[3-4] changes in unemployment seem to correlate strongly with trends in people's perception that cost is a barrier to obtaining med-

[3] State- and sex-specific prevalence of selected characteristics—behavioral risk factor surveillance system, 1994 and 1995. MMWR CDC Surveill Summ 1997;46(3):1-31.

[4] Centers for Disease Control and Prevention, Health, United States, 1996-97: injury chartbook, Hyattsville, Md.; National Center for Health Statistics, 1997.

ical care. This makes sense, given the reliance in the United States on employer-based health insurance. Concern about health care costs and pressure for health care reform may increase in conjunction with increases in unemployment, as occurred from January 1991 to January 1993.

DAVID E. NELSON, M.D., M.P.H.
BETSY L. THOMPSON, M.D., M.S.P.H.
SHAYNE D. BLAND, M.S.

Centers for Disease Control and Prevention
Atlanta, GA 30341-3717

[Registered Marks BC and BS Assn.]

BLUECROSS OF NORTHEASTERN PENNSYLVANIA
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EXCLUSIONS

Except as specifically provided in this booklet, you are not covered for the following:

Services which are not prescribed by or performed by or billed by a Professional Provider.

Services which are not medically necessary as determined by Blue Shield.

Services, supplies or charges that are experimental or investigational in nature.

Services performed in a facility by a Professional Provider who in any case is compensated by the facility for similar services performed for patients.

Services performed by a Professional Provider enrolled in an education or training program when such services are related to the education or training program.

Services which are paid, or payable, in whole or in part, by a Blue Cross Plan.

Services which are incurred prior to your effective date or during an inpatient admission that commenced prior to your effective date.

Services which are incurred after the date of termination of your coverage unless otherwise indicated.

Services for any illness or bodily injury which occurs in the course of employment if benefits or compensation are available, in whole or in part, under the provisions of any legislation of any governmental unit. This

exclusion applies whether or not you claim the benefits or compensation.

Services received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group.

Services for any illness or injury suffered after your effective date as a result of an act of war.

Charges submitted by a Certified Registered Nurse and another Professional Provider for the same services performed on the same date for the same patient.

Service which you have no legal obligation to pay in the absence of this or similar coverage.

Services provided by any governmental unit.

Services which are provided by the Veteran's Administration by the Department of Defense for active military personnel for which you are eligible if you have not taken the necessary action to obtain such benefits.

Equipment costs related to services performed on high cost technological equipment as defined by Blue Shield, such as but not limited to computed tomography (CT) Scanners, Magnetic Resonance Imaging (MRI) and extracorporeal shock wave lithotripters unless the acquisition of such equipment by a Professional Provider was approved through a Certificate of Need (CON) process and/or Blue Shield.

Payment made under Medicare when Medicare is primary, or would have been made if you had enrolled for Medicare and claimed Medicare benefits. However, this exclusion shall not apply when the Group is obligated by law to offer the Subscriber all the benefits of this contract and the Subscriber so elects this coverage as primary.

The Scranton Times—Thursday, February 25, 1988

REALLOCATION PROPOSAL GETS SWIF BOARD NOD

The State Workmen's Insurance Fund board of directors has endorsed Gov. Robert P. Casey's proposal to reallocate $221 million from the fund's surplus reserve accounts for economic development purposes.

"In recent years, the state's Workmen's Insurance Fund has seen its assets swell to nearly $1 billion," said Harris Wofford, secretary of Labor and Industry and chairman of the SWIF board.

"The board's endorsement of these initiatives not only will further economic development throughout the commonwealth, it also sends a clear signal that investigating in Pennsylvania's economic future makes good business sense," Wofford said.

The state Legislature must now act on Casey's proposal—which is part of his plan to pay off Pennsylvania's once massive Unemployment Compensation debt to the federal government.

If the debt is paid off by November, it is estimated that Pennsylvania employers will save $475 million in payroll taxes for 1989.

On Feb. 5, Casey announced a way to repay the state's remaining $195 million debt to the federal government with $146 million from the Unemployment Compensation Trust Fund, and another $49 million surplus from the Unemployment Interest Fund.

As part of the governor's plan, a $146 million "reserve fund" will be created using SWIF excess funds. That fund would be used only if the unemployment fund falls below a predetermined level.

Casey urged the Legislature to approve the use of Workmen's Insurance Fund monies for the reserve ac-

count, and instructed the Unemployment Compensation Advisory Council to design a "trigger mechanism" that would assure the UC Fund's continued solvency.

In a separate action, the board authorized the investment of up to $15 million of assets in an investment fund that targets loans to Pennsylvania businesses.

The board also directed its finance committee to recommend a way to invest in the Pennsylvania Private Placement Separate Account.

The fund, designed in 1983 by the MILRITE Council, will target its investments to Pennsylvania-based companies that don't have access to public bond markets to finance expansion and modernization projects.

Other investors in the fund include corporate, union and public pension funds.

Investment in the account by SWIF would require final approval by the board.

The boards' actions follows a review of the fund's financial condition by Huggins Financial Services Inc. The review determined that the fund has accumulated monies from its investments substantially in excess of the amount required to protect the interests of policyholders, claimants and the Fund.

SWIF, a state-run insurance company with its headquarters in Scranton, provides workers' compensation insurance protection to Pennsylvania state workers and other employers in the commonwealth.

As of Jan. 31, SWIF had assets of nearly $1 billion.

The Scranton Times—April 20, 1992

CLOSED BANKS SET TO REOPEN

HARRISBURG (AP)—Two private banks closed by the state for poor management were set to reopen today as newly-chartered and federally-insured state banks.

Reading-based Knoblauch State Bank and Marian State Bank in Philadelphia were scheduled to open at 9 a.m., Sarah W. Hargrove, state banking secretary, said in a statement.

The state Department of Banking closed the banks known as Tobias Knoblauch Private Bank and Marian Bank on Friday, citing management that posed a risk to depositors' money.

Tobias Knoblauch, which has branches in Reading, Villanova and Philadelphia, had inadequate capital, while Marian was insolvent. Hargrove said Friday.

The deprtment and a team of banking officials worked through the weekend to have bank deposits up to $100,000 insured by the Federal Deposit Insurance Corporation.

The reopened banks are owned by the State Workmen's Insurance Fund, which can provide capital to keep them in operation.

Customers who had deposits that exceeded $100,000 at the closed banks will be contacted and told how to file a claim for amounts that may be uninsured.

Reading Eagle—April 18, 1993

DEAD BANK'S GHOST
HAUNTS COURTS

• The seizure of the Tobias Knoblauch Private Bank spawns a protracted legal dispute that devours time and money. There appears to be no end in sight.

By Don Spatz
Eagle Times

A year ago—on April 17, 1992—state Banking Secretary Sarah W. Hargrove seized the ailing Tobias Knoblauch Private Bank in Reading, touching off a complex court battle that will last at least through the summer and perhaps till next year.

The bickering continues both inside and outside of court, as the sides seem to want to take their cases both to the judge and to the public.

"We are amazed, disappointed and incredulous . . . that the actions of the general partners (of Knoblauch) are distorting the facts as well as drawing attention away from what we see as the bottom line: They mismanaged the bank, for which they are personally responsible," said Banking Department spokeswoman Stephanie G. Maurer.

"It's difficult to believe a Cabinet-level officer of the commonwealth could be in such incredible violation of the law," said attorney Alan S. Fellheimer, who represents the general partners. "But this person (Hargrove) absolutely refuses to follow the law."

After 12 months of legal wrangling—through more than a dozen separate cases, nearly 4,000 pages of testimony, more than 100 exhibits, hundreds of separate written arguments and objections, dozens of hearings, and millions of dollars in legal fees and expenses—several points are evident:

• No out-of-court settlement seems likely, despite six months of pressure by Berks County President Judge Forrest G. Schaeffer Jr. Instead, the sides seem to have dug deeper into their trenches.

Schaeffer is presiding over most of the suits, those filed in county court. Others have been filed in Commonwealth Court and in U.S. District Court. Most are complaints lodged by Knoblauch's partners against Hargrove.

• Failing a settlement, the case could take years. Whatever Schaeffer's ultimate decision, it likely will be appealed because the political and financial stakes are so high.

• The legal battle's expenses are rapidly approaching the amounts suggested to settle the case.

When Hargrove seized the bank April 17—immediately after winning Schaeffer's approval during a secret hearing—she claimed it was near insolvency and was being run in an unsafe and unsound manner by its partners: Hugh Kenworthy III, W. Thomas Tither, William R. Dimeling, and John C. Tuten.

She transferred its best assets and insured deposits to the new Knoblauch State Bank, operating ever since. Its uninsured deposits—portions of accounts above $100,000—and worst assets were kept in the receivership, and about 200 uninsured depositors were told they may not get all their money back.

But the partners cried foul. They claimed the ailing bank was getting back on its feet when Hargrove seized it and alleged she misled Schaeffer and broke numerous state laws regarding bank seizures and disposal of bank assets. The court battle began.

Schaefer boiled down the intertwining cases to three bank questions: Did Hargrove properly seize the bank? Did the later properly dispense of its assets? Are there any damages to be awarded to anyone?

So far, testimony has been heard on only the first.

From August through January, Schaeffer tried to get the parties to settle. They didn't. In January, he vacated his order approving the seizure, but did not void the seizure itself.

The attorneys prepared to dig into the case again. In March, Schaeffer issued a three-page agenda scheduling new arguments and deadlines through August to deal with the remaining issues of just the first question. However, that agenda already is weeks behind schedule.

The case is becoming one of the more expansive disputes in county court. The state Banking Department has said it spent nearly $500,000 through December, just for its outside law firm handling the local cases. (The cases are so complex, the law firm brings three attorneys to each hearing: one of them does nothing but keep track of the numerous documents.)

Then there is the time expended on the case by the department's staff attorneys, by Hargrove and several of her officials, who have spent many weeks in court and in depositions and by attorneys for several sets of general partners, two sets of limited partners, a class of uninsured depositors, the state bank, and the State Workmen's Insurance Fund, which owns the state bank. There are private stenographers and other hefty paper-shuffling expenses.

Maurer, the state Banking Department spokeswoman, said the case has created a lot more work, requiring employees to put in many extra hours, but the department is accomplishing its other regulatory tasks.

"It's not something we mind," she said. "We feel we're fighting for something that's right and that ordinary people would want to see addressed."

She also said the department is not frustrated by the duration of the case.

"Fighting for something right is never frustrating," she said.

But Fellheimer said he's frustrated.

"The case is taking a long time," he said. "We lost six months while they tried to settle it. I can't blame the judge for that. But I think that the unfortunate thing about this case is that it never had to happen."

Back to the bickering.

Fellheimer repeats the partners' long-standing contention: Hargrove broke the law.

"She (Hargrove) has acted to the detriment of my clients in total disregard of the statutes," Fellheimer said. "The Legislature goes to a lot of trouble to write laws . . . and the secretary (Hargrove) says, 'I'll ignore them and do it my way.'

"But that's what the Legislature is for, to protect us against runaway officials. I think the courts are realizing that, and will ultimately require them (state officials) to make good."

Maurer repeats the state's long-standing contention: The partners mismanaged the bank and gave themselves preferential treatment with depositors' money.

"They lent money to themselves beyond their legal limits . . . and made loans to themselves at better rates than other (customers) in Reading had access to," she said.

She said those above-the-limit loans ranged from $535,000 for Tuten to $1.4 million for Tither. She also accused the partners of not repaying those loans and constantly bouncing checks.

Meanwhile, the case widens.

In the last month, the partners have sued Hargrove to return $4 million they claim she illegally took from the

Pennsylvania Deposit Insurance Corp., which insured private bank deposits. And Hargrove has sued the partners for what could be $6 million to pay off those uninsured depositors.

In her suit, Hargrove also named as a defendant Richard A. Ehst, the former Knoblauch president who left in 1989 and returned as a consultant in February 1991 to help it straighten out its finances.

Strangely conspicuous by his absence from Hargrove's suit, however, was James T. Klein, the bank president from 1989 to February 1991, when he left to join Security First Bancorp in Media. Most of Hargrove's suit deals with the time period of Klein's tenure, but he is not even mentioned.

"We believe Jim Klein inherited a lot of problems," Maurer explained. "Ehst was there at a critical time and had an active hand in management; that's why he's named."

* * * *

Reading Eagle—April 18, 1993

WILL BANK SUCCESSOR SUCCEED?

■ Knoblauch State Bank is turning around, but will it sell?

By Don Spatz
Eagle Times

Born in a firestorm, the Knoblauch State Bank will quietly celebrate its first anniversary Tuesday with hopes it may actually make a profit by the end of the year.

But President John J. Brine, brought in to get the bank ready for sale, said the widening controversy surrounding its predecessor—the Tobias Knoblauch Private Bank—makes it unlikely the state bank can be sold by an April 1994 deadline.

For the moment, it still is trying to keep its customers comfortable and seems to be successful, Brine said.

"WE'RE doing the blocking and tackling, day by day, building up the deposit base, building up the loan customers. We're operating at a break-even basis. We expect to be earning money by the end of the year."

John J. Brine
president, Knoblauch State Bank

"This is a slow-recovery kind of industry," he said. "We're doing the blocking and tackling, day by day, building up the deposit base, building up the loan customers. We're operating at a break-even basis. We expect to be earning money by the end of the year."

The state banking department created Knoblauch State Bank to take over after Banking Secretary Sarah W. Hargrove seized the private bank on April 17, 1992, on the grounds it was on the brink of collapse. The private bank

partners cried foul and sued Hargrove, and the case remains in court.

The State Workman's Insurance Fund bought the new state bank as an investment for $17 million, intending to sell it in two years.

SWIF has a guaranteed profit; if it can't make a profit on the sale, it has been promised taxpayers' money from the general fund. But SWIF can't sell the bank until the suit is resolved.

Knoblauch opened amid the controversy's first shots, and Brine said there "were a couple of months where we ended up operating in a crisis situation . . ."

"We probably had more disturbances than most successor managements in other places," he said. "It took awhile to deal with it, and it took awhile for customers to deal with it in their own way."

One way was withdrawals; the bank lost more than $28 million in deposits in its first months. Although its operations remained profitable, it took an $625,000 loss for 1992 because of problem loans and legal expenses.

Brine said deposits and the rest of its core business have since stabilized, but he noted the court case length and publicity "has impeded our ability to make the most that can be made out of the (state) bank. With significant suits still outstanding, it's probably impossible" for SWIF to make its deadline, he said.

SWIF spokesman Frank Lynch would not comment on that possibility, but said that given the same situation, SWIF would buy another bank.

"You have to look at the investment two ways," he said. "One is public responsibility; there were 15,000 families with their deposits at risk. Luckily, SWIF was in a position to do something about that.

"Strictly on the investment side, SWIF is well protected with the guarantee. We have had no second thoughts about that."

Supreme Court, U.S.
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DEC 8 1998

No. 97-2000

IN THE
Supreme Court of the United States
OCTOBER TERM, 1998

AMERICAN MANUFACTURERS MUTUAL INSURANCE COMPANY, *et al.*,
Petitioners,
v.
DELORES SCOTT SULLIVAN, *et al.*,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Third Circuit

BRIEF FOR PENNSYLVANIA FEDERATION OF INJURED WORKERS AS AMICUS CURIAE SUPPORTING RESPONDENTS

RODERICK M. HILLS, JR.
Assistant Professor of Law
THE UNIVERSITY OF MICHIGAN LAW SCHOOL
625 South State Street
Ann Arbor, Michigan 48109-1215
(734) 763-9635

RICHARD W. MCHUGH
Counsel of Record
MICHIGAN POVERTY LAW PROGRAM-WEST
611 Church Street, Suite 4D
Ann Arbor, Michigan 48104-3000
(734) 332-1015
Counsel for Amicus Curiae

WILSON - EPES PRINTING CO., INC. - 789-0096 - WASHINGTON, D.C. 20001

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QUESTIONS PRESENTED

1. Whether insurance companies were "state actors" when, acting in conjunction with a state agency, they used statutory provisions authorizing them to stop payments for workers' compensation medical benefits that were, by law, disabled workers' exclusive source of medical benefits?

2. Whether due process requires that disabled workers get prior notice and an opportunity to be heard before their workers' compensation medical benefits can be indefinitely suspended for months or years until utilization review and administrative hearings can be completed?

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R. Larson, *Law of Workers' Compensation* (1991) 15
O. Kramer and R. Briffault, *Workers Compensation: Strengthening the Social Compact* (1991, Insurance Information Institute Press) 8
Report of the National Commission on State Workmen's Compensation Laws (1972) 17
Texas Jur. 3d, "Work Injury Compensation" (1991) 9

IN THE

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v.

DELORES SCOTT SULLIVAN, *et al.*,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Third Circuit

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BRIEF FOR PENNSYLVANIA FEDERATION OF INJURED WORKERS AS AMICUS CURIAE SUPPORTING RESPONDENTS

INTEREST OF THE *AMICUS CURIAE*

The Pennsylvania Federation of Injured Workers is a statewide organization of injured workers and their families with approximately two thousand members organized into ten local chapters.[1] The overwhelming number of

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[1] Pursuant to Supreme Court Rule 37.6, counsel for *amicus* Federation state that no counsel for a party authored this brief in whole or in part; and that no person or entity, other than *amicus* and its counsel contributed to the preparation of this brief. Because the *Amicus* Federation is unable to afford the cost of printed briefs, the Pennsylvania AFL-CIO has agreed to pay the costs of printing and service of the brief. Written general consents by the parties to the filing of this brief have been lodged with the Clerk.

injured worker members of the Federation are recipients of, or applicants for, workers' compensation benefits under the Pennsylvania Workers' Compensation Act. The Federation was organized in 1995 in order to advocate for the medical, social and legal needs of injured workers in Pennsylvania and to assist injured workers in obtaining compensation for their workplace injuries.

Pennsylvania's challenged supersedeas provision, which permitted insurance companies to terminate workers' compensation medical benefits without prior notice or an opportunity to be heard for the injured worker, left many of these workers without meaningful alternatives for obtaining care for their injuries in the months or years of administrative proceedings required to obtain reinstatement. Because this Court's decision will have an important impact on the rights of its members and other injured workers in Pennsylvania, the Federation offers its views in this brief in support of the Respondents.

SUMMARY OF ARGUMENT

The Fourteenth Amendment prohibits a "State" from "depriv[ing] any person of life, liberty, or property without due process of law." Section 1983, in turn, provides a remedy against "[e]very person" for any such "deprivations" occurring "under color of any statute, ordinance, regulation, custom, or usage, of any State. . . ." Rev. Stat. § 1979, 42 U.S.C. § 1983.

This Court has repeatedly held that where private defendants infringe federal rights and the actions are "fairly attributable to the State," these private parties are "state actors" for purposes of the Fourteenth Amendment. *West v. Atkins*, 487 U.S. 42, 54 (1988) (Blackman, J.). In addition, where these defendants "have exercised power 'possessed only because the wrongdoer is clothed with the authority of state law,' " they have acted "under color of state law" for purposes of Section 1983. *Id.* 49 (quoting *United States v. Classic*, 313 U.S. 299, 326 (1941).

Pennsylvania adopted the 1993 legislation challenged in this appeal to cut the costs of medical care under its workers' compensation law. The major mechanism selected was permitting employers and their insurance companies to pick injured workers for what was termed "utilization review." After their selection for utilization review by their employer or its insurer (and the Commonwealth's initial approval of the application for utilization review), these workers had their medical benefit payments suspended by supersedeas *at the behest of insurers and prior to any third parties' indication of any legitimate concern regarding their medical treatment.*

As a result, admittedly disabled workers—*whose sole legal remedy for obtaining medical care for their work-related injuries was workers' compensation benefits*—lost their medical benefits for periods of months or years. And, as the final straw, the state authorized the insurer's to invoke supersedeas without prior notice to the injured worker or an opportunity by the injured worker to be heard on the proposed suspension of his or her medical benefits.

Nevertheless, before this Court, petitioner insurance companies seek to escape any monetary responsibility for the damages they caused to injured workers by their suspensions of workers' compensation medical benefits through the supersedeas provisions of Act 44. Petitioners claim that they were not "state actors" when they invoked the utilization review and supersedeas provisions of Pennsylvania law to stop injured workers medical benefits without prior notice or an opportunity to be heard.

The reality of Pennsylvania's supersedeas procedure and the principles flowing from this Court's state action decisions dictate otherwise. In particular, the insurance companies' statutory invocation of supersedeas—prior to any medical determination concerning the appropriate medical treatment of disabled workers—and stopping the exclusive source of payments for disabled workers' medi-

cal care—are "fairly attributable to the State." For this reason, they fall well within the ambit of "state action" as defined by this Court in *Edmonson v. Leesville Concrete Co.*, 500 U.S. 614 (1991); *Tulsa Profession Collection Services v. Pope*, 485 U.S. 478 (1988); and *Blum v. Yaretsky*, 457 U.S. 991 (1982).

Amicus Federation further addresses arguments advanced by petitioners and their *amici* regarding a host of supposed misfortunes that will befall workers' compensation and utilization review as a result of the holding below. In fact, we show that the Third Circuit's due process ruling in this case is consistent with reported state cases from many other jurisdictions requiring prior notice and an opportunity to be heard prior to stopping workers' compensation benefits. Finally, even with due regard for medical cost containment, there is simply no validity in an argument that legitimate utilization review requires stopping workers' compensation medical care prospectively for disabled workers without any prior notice to the injured worker and an opportunity to offer evidence contesting the proposed suspension of medical benefits.

As we now show in greater detail, the decision of the Court of Appeals for the Third Circuit should be affirmed.

ARGUMENT

I. INSURANCE COMPANIES WERE "STATE ACTORS" WHEN THEY USED STATUTORY PROVISIONS GIVING THEM AUTHORITY TO STOP, WITHOUT PRIOR NOTICE OR AN OPPORTUNITY TO BE HEARD, WORKERS' COMPENSATION PAYMENTS THAT WERE DISABLED WORKERS' EXCLUSIVE SOURCE OF MEDICAL BENEFITS.

Where private defendants infringe federal rights and their actions are "fairly attributable to the State," these private parties are "state actors" for purposes of the Fourteenth Amendment. *West v. Atkins*, 487 U.S. 42, 54 (1988) (Blackman, J.). In addition, where private

defendants "have exercised power 'possessed only because the wrongdoer is clothed with the authority of state law,' " they have acted "under color of state law" for purposes of Section 1983. *Id.* 49 (quoting *United States v. Classic*, 313 U.S. 299, 326 (1941).

Here, all must agree that workers' compensation medical benefits are a form of property protected from deprivation by the Fourteenth Amendment. Indeed, because these statutory benefits are creatures of state law[2] and a compelled substitute for injured workers' common law tort causes of action against their employers for work-related injuries,[3] there can be no question in this regard.[4] *Sullivan v. Barnett*, 139 F.3d 158, 168 n. 18 (3rd Cir. 1998) (and accompanying text) *cert. granted* No. 97-2000 (September 29, 1998).

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[2] Pennsylvania Workers Compensation Act, 77 Pa. Stat. Ann. § 1 *et seq. See especially* 77 Pa. Stat. Ann. § 1053 requiring the Commonwealth to establish a fund to pay workers' compensation benefits to eligible employes in the event that workers' compensation insurers are insolvent.

[3] Pennsylvania enacted its workers' compensation law pursuant to a 1915 constitutional amendment, Article III, § 21, which is now remembered as Article III, § 18. *See* Purdon's Pa. Stat. Art. 3, § 18 and historical notes. The amendment specifically authorized the General Assembly to provide for a compensation system "regardless of fault" for injuries and diseases arising in the course of employment and limiting the amount of recovery for those injuries. The Act provides that "The liability of an employer under this act shall be exclusive and in the place of any and all other liability to such employe[e]s . . . or anyone otherwise entitled to damages in any action at law or otherwise on account of any injury or death." 77 Pa. Stat. Ann. § 481(a).

[4] Statutory public benefits, like workers' compensation benefits, have been repeatedly characterized as property interests protected by due process. In addition, because a "cause of action is a species of property protected by the Fourteenth Amendment's Due Process Clause," *Logan v. Zimmerman Brush Co.*, 455 U.S. 422, 428 (1982), the state's mandatory substitution of workers' compensation benefits for common law remedies likewise renders that substitute a protected property interest.

From 1984 until 1993, Pennsylvania did not suspend workers' compensation wage loss or medical benefits to injured workers without the consent of a worker or an order of a workers' compensation administrative law judge. This was the outcome of *Baksalary v. Smith*, 579 F.Supp. 218 (E.D. Pa. 1984) (three-judge court), *appeal dismissed sub nom. Allstate Insurance Co. v. Baksalary*, 469 U.S. 1146 (1985), *aff'd* 772 F.2d 893 (3rd Cir. 1985), and a consent decree concluding that case by preventing the use of supersedeas to stop workers' compensation benefits without due process of law. *Baksalary v. Smith*, 591 F.Supp. 1279 (E.D. Pa. 1984) (approving consent decree).

In July 1993, the Legislature passed Act 44 to restore supersedeas suspensions of workers' compensation medical benefits under the guise of "utilization review." Codified as 77 Pa. Stat. Ann. § 531(5) and (6). Given the favorable outcome below on respondents' due process facial challenge to the constitutionality of the restored supersedeas provision, and the Commonwealth's modification of its supersedeas procedure[5] following this Court's denial of its petition for certiorari,[6] injured workers in Pennsylvania should no longer have their workers' compensation medical benefits suspended without notice and an opportunity to be heard.

This Court has relied upon a number of tests or factors in its cases interpreting the "state action" requirement of the Fourteenth Amendment and the closely related "color of law" requirement of Section 1983. *Amicus* Federation believes that a determination of "state action" arises in this case from the proper application of interrelated factors presented by Pennsylvania's workers' compensation law and its challenged supersedeas provision. Taken together, these factors compel the conclusion that the in-

[5] *See* Joint Appendix, 50, 53.

[6] *Butler v. Sullivan*, No. 98-161, *cert. den.* October 5, 1993.

surer's exercise of explicit statutory authority to invoke supersedeas suspensions of medical benefits under Act 44 was "fairly attributable to the state" and the Court of Appeals' decision in this regard should be affirmed.

In determining whether a nominally private party is a "state actor," this Court "ask[s] first whether the claimed constitutional deprivation resulted from the exercise of a right or privilege having its source in state authority, . . . and, second whether the private party charged with the deprivation could be described in all fairness as a state actor." *Edmonson v. Leesville Concrete Co.*, 500 U.S. 614, 620 (1991) (Kennedy, J.) (citations omitted). Cast in somewhat different terms, the Court has held that a complaining party must "show a sufficiently close nexus between the State and the challenged action of the regulated entity so that the action of the latter may be fairly treated as that of the State itself." *Blum v. Yaretsky*, 457 U.S. 991, 1004 (1982).

Here, the overall context for supersedeas suspensions of workers' compensation medical benefits in a governmental benefits program, the explicit statutory authorization of supersedeas, and the specific role played by insurers and the state agency in invoking supersedeas all compel a conclusion that petitioner insurance companies are "state actors" for purposes of their involvement in the supersedeas process.

To begin, workers' compensation is properly characterized as a "traditional government fuction" carried out by the State. In fact, only a State can replace workers' common law rights to sue their employers in tort for workplace injuries—seeking pain and suffering damages, as well as punitive damages—and substitute workers' compensation wage loss and medical benefits in their stead.[7] In order to effectuate this substitution of remedies

[7] Workers' compensation laws were passsed to provide, on a no-fault basis, partial wage replacement and medical benefits to em-

for employment-related injuries and disease, workers' compensation is the exclusive remedy for injuries and diseases arising within the scope of employment in Pennsylvania. 77 Pa. Stat. Ann. § 481(a) (quoted in note 2, *supra*).

In our view, the exclusive role played by workers' compensation in Pennsylvania is highly significant. This Court's early government function state action cases "had one thing in common: exclusivity." *Edmonson v. Leesville Concrete*, 500 U.S. at 640 (O'Connor, J., dissenting) (discussing *Terry v. Adams*, 345 U.S. 461 (1953); *Marsh v. Alabama*, 325 U.S. 501 (1946); *Smith v. Allwright*, 321 U.S. 649 (1944); and *Nixon v. Condon*, 286 U.S. 73 (1932)). And, exclusivity is an element in more recent decisions finding state action as well. *West v. Atkins*, 487 U.S. at 54-55 ("Under state law, the only medical care [prisoner] West could receive for his injury was that provided by the State.") and *Edmonson*, 500 U.S. at 622 ("[P]eremptory challenges have no utility outside the jury system, a system which the government alone administers.")

Here, the Commonwealth compelled injured workers to use workers' compensation medical benefits exclusively to obtain medical care for their work-related injuries and disease. This exclusivity feature of workers compensation, combined with Pennsylvania's statutory guarantee

ployees injured in the scope of their employment. Workers lost their common law rights to sue employers in tort for compensatory and punitive damages. As a result of this "legislated compromise," employers gained tort immunity and workers' compensation became the exclusive means of addressing wage continuation benefits and medical coverage for injured workers. *Washington Metropolitan Area Transit Authority v. Johnson*, 467 U.S. 925, 931-932 (1984) (Marshall, J.). At the same time, employers lost three tort defenses for negligence actions (referred to as the "Unholy Trinity"); the "fellow servant" rule, contributory negligence, and assumption of risk. Kramer, O. and Richard Briffault, *Workers Compensation: Strengthening the Social Compact* (1991, Insurance Information Institute Press), 13-16. *See also, New York Central RR v. White*, 243 U.S. 188, 197-201 (1917).

of benefits, dictates a finding that workers' compensation benefits serve a traditional public function in Pennsylvania.[8]

Just as significantly for state action purposes, Act 44's supersedeas provision and its implementing regulations authorized insurance companies or self-insured employers to perform a "traditionally governmental function" within the workers' compensation program—the suspension of injured workers' medical benefits through initiation of supersedeas. As the court below wrote:

> The right to invoke the supersedeas, or to stop payments, is a power that traditionally was held in the hands of the state. When insurance companies invoke the supersedeas (i.e., suspension) of an employee's medical benefits, they compromise an employee's State-created entitlements.

Sullivan v. Barnett, 139 F.3d at 168.

While Act 44's supersedeas procedure took place in the context of so-called "utilization review," there is no congruence between legitimate utilization review of medical treatment and Pennsylvania's automatic suspension of future payments for medical treatment—*invoked not as a result of utilization review by a neutral party, but on the motion of the party initiating the review and prior to the*

[8] Obviously, the state action question will differ according to each state's workers' compensation law. For example, Texas is one of the few states in which workers' compensation is voluntary. "In states that have compulsory compensation acts, the right of an injured employee to compensation for his or her injuries ordinarily rests on the idea of status rather than that of implied contract. But in Texas coverage is elective and the legal relation that arises between the employee, the employer, and the insurer who bring themselves within the scope of operation of the workers' compensation laws is contractual." 75 Tex. Jur. 3d, Work Injury Compensation § 5 at 46 (1991). For this reason, *Barnes v. Lehman*, 861 F.2d 1383 (5th Cir. 1988), cited by petitioners, arises out of an entirely different legal context and is inapplicable here.

utilization review taking place.[9] As a result, supersedeas is more, in terms of its impact, than a dispute over a medical bill. In the case of injured workers with chronic conditions or ongoing treatments, supersedeas operates as an effective termination of medical benefits pending the outcome of administrative hearings.

For state action purposes, this central role of private insurers in the suspension of workers' compensation medical benefits is critical. In *Blum v. Yaretsky*, 457 U.S. 991 (1982) (Rhenquist, J.), this Court drew a careful distinction between private physician and administrator certifications of need used in determining the level of nursing home care appropriate for Medicaid recipients and subsequent state adjustments in the level of Medicaid reimbursements for that care in reaction to those certifications.

> The [certification] decisions about which respondents complain are made by physicians and nursing home administrators, all of whom are concededly private parties. There is no suggestion that those decisions were influenced in any degree by the State's obligation to adjust benefits in conformity with changes in the cost of medically necessary care.

Blum, 457 U.S. at 1005. Rejecting the dissenting justices' argument that the certifying phsyicians' were not properly considered "private judgments about the health needs of patients," Justice Rehnqust noted for the Court that

> Transfers to lower levels of care . . . occur only *after* an assessment of [the patients' health] needs.

[9] Once the utilization review form was submitted by the insurance company or employer, it was reviewed by the state Bureau of Workers' Compensation and approved if all information was provided. If approved, the employer or insurer could invoke supersedeas to suspend payments of medical benefits for the duration of the utilization review process, unless and until the suspension was reversed by a workers' compensation judge. *See* 34 Pa. Code § 127.208(e) (1996), quoted at 139 F.3d at 164 n.2 and accompanying text.

> In other words, although 'downward' transfers are made possible and encouraged for efficiency reasons, they can occur only *after* the decision is made that the patient does not need the care he or she is currently receiving. . . . *That judgment is a medical one, not a question of accounting.*

457 U.S. at 1008 n. 19 (emphasis added). *See also* 457 U.S. at 1008 and 457 U.S. at 1012 (White, J. concurring).

In contrast to the level of care certifications in *Blum*, what Act 44 sought and accomplished was a quick and easy means of cutting medical costs in Pennsylvania's workers' compensation program.[10] Without any need for a particularized showing that continued care was inappropriate, overpriced, or excessive, insurance companies had the legal power and the economic incentive to invoke supersedeas.

As a result of the exclusive remedy provision of its law, Pennsylvania workers already deemed disabled by workplace injuries whose medical benefits were stopped by supersedeas were denied medical coverage for their treatment for the months or years until their cases could be heard by a workers' compensation judge. Unless they were lucky enough to have a medical provider willing to risk not getting later reimbursement, supersedeas was tantamount to an indefinite, *ex parte* suspension of workers' compensation medical benefits for workers with chronic injuries or diseases requiring continuing care.

[10] This case likewise differs from the exercise of professional judgment by a public defender in *Polk County v. Dodson*, 454 U.S. 312 (1981). There, this Court held that when representing an indigent criminal defendant a public defender was not acting under color of state law. In particular, in reaching its conclusion this Court relied upon the independence of the defense attorney's judgment under neutral ethical standards and the adversarial relationship between criminal defense attorneys and the state. 454 U.S. 318-320. In this case, the state and the petitioner insurance companies were far from adversarial. In fact, invocation by insurers of supersedeas prior to any neutral parties' involvement in utilization review advanced the shared interests of the state and the insurance companies in medical cost cutting.

Clearly then, the insurers invoking supersedeas crossed the line between "medical" decisions and "accounting" decisions and, as well, between "private" action and "state" action. Because they crossed this line between private functions and governmental functions, the Petitioners' actions can be "fairly attributed" to the state as part and parcel of the state's workers' compensation cost containment scheme.

As noted by the Third Circuit, the "purpose of Act 44 was to contain the spiraling costs of medical treatment for work-related injuries." *Sullivan v. Barnett*, 139 F.3d at 162. Concomitant with medical cost containment, of course, were increased profits for the insurance companies and an improved "business climate" for the Commonwealth—goals that both these parties were willing to jointly advance by terminating workers' compensation medical benefits through a so-called "utilization review" process.[11] Significantly, this process, by design, excluded admittedly injured workers from involvement and ensured that they could not effectively restore their medical benefits for months, if not years, after the supersedeas was invoked by the involved insurers. Accordingly, the Third

[11] Petitioners and their *amici* spend a good deal of their briefs recounting a "parade of horribles" that they allege will follow if this Court affirms the Third Circuit's state action holding. However, petitioners have failed, in our view, to explain why legitimate utilization review requires the exclusion of injured workers and the termination of medical benefits without prior notice and an opportunity to be heard. Indeed, as we discuss later, state courts have agreed with the Third Circuit's due process holding, either upon the basis of due process or based upon an application of their state's workers' compensation law. Moreover, the fact that private insurance companies are state actors for purposes of supersedeas does not make them state actors for all other purposes. *Compare Polk County v. Dodson*, 454 U.S. 312 (1981) (public defender not acting under color of law when acting as attorney for indigent criminal defendant) *with Tower v. Glover*, 467 U.S. 914 (1984) (O'Connor, J.) (alleged conspiracy between state public defenders and other public officials satisfies "color of law" requirement of Section 1983).

Circuit's characterization of petitioner insurance companies as "a partner or an arm of the State" was wholly accurate.

"[W]hen private parties make use of state procedures with the overt, significant assistance of state officials, state action may be found." *Tulsa Profession Collection Services v. Pope*, 485 U.S. 478, 486 (1988) (O'Connor, J.). Pennsylvania's scheme for supersedeas suspensions of medical benefits in Act 44 created a process in which the Bureau of Workers' Compensation and private insurers acted in concert to reduce medical benefits for injured workers with the specific authority of state law. The close interaction and extent of state agency involvement are recounted in detail in the opinion below. *See Sullivan v. Barnett*, 139 F.3d at 162-165.

In *Tulsa Professional Services*, this Court found a probate court's appointment of an executor or executrix (triggering the operation of the nonclaim statute), the use of court forms requiring the publication of notice regarding the filing of claims, and the filing of the published notices with the probate court constituted "significant state action." 485 U.S. 487. In our view, the degree of state involvement in supersedeas under the challenged Pennsylvania statute rises well above the level of state action deemed "pervasive and substantial" in *Tulsa Professional Services*, 485 U.S. at 487.

Here, petitioners' use of supersedeas was authorized, not mandated, by Act 44, Pa. Stat. Ann. § 531(6), and its implementing regulations, Pa. Code § 127.208(e). Therefore, petitioners were willing participants in the supersedeas suspensions of disabled workers' medical benefits and cannot in any sense portray themselves as bystanders to a "self-executing" medical review process carried out by the state.[12]

[12] In *Lugar v. Edmondson Oil Co.*, 457 U.S. 922 (1981) (White, J.), this Court held that a private creditor corporation and its

Certainly, Pennsylvania's use of supersedeas in its workers' compensation system far exceeds the level of state action deemed sufficient to reach private parties in other cases. For example, this Court has held that the use by private parties or peremptory challenges in civil cases constitutes state action, *Edmonson v. Leesville Concrete Co.*, 500 U.S. 614 (1991), and that private physicians acting as prison doctors are state actors in that setting, *West v. Atkins*, 487 U.S. 42 (1988).

When examined closely, the legal and factual context involved in the indefinite suspension of workers' compensation medical benefits by the petitioners was with the significant, overt encouragement of the state, so "that the choice must in law be deemed to be that of the State." *Blum v. Yaretsky*, 457 U.S. 1004 (Rehnquist, J.). Because the Court of Appeals properly assessed the petitioners' role in invoking Pennsylvania's workers' compensation supersedeas to stop medical benefits to disabled workers, the petitioners were properly held to be state actors and the judgment below must be affirmed.

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president were state actors when using an unconstitutional state pre-judgment attachment statute in conjunction with state officers. Three dissenting jutices expressed a concern in *Lugar* that treating a private citizen as a state actor for simply commencing a legal action was "plainly unjust." 457 U.S. at 945-9446 (Powell, J., dissenting with Rehnquist, J. and O'Connor, J.). The petitioners' willing invocation of supersedeas eliminates any such fairness concerts here, especially in light of what this Court termed the "obvious incentive unilaterally to cease payments" that the insurers will otherwise not be able to recover if utilization review later finds medical benefits were properly terminated. *Dillard v. Industrial Commission of Virginia*, 416 U.S. 786, 789 (1974) (Powell, J.).

II. DUE PROCESS REQUIREMENTS OF NOTICE AND AN OPPORTUNITY TO BE HEARD PRIOR TO INDEFINITE SUSPENSION OF WORKERS' COMPENSATION MEDICAL BENEFITS DO NOT CONFLICT WITH LEGITIMATE UTILIZATION REVIEW.

The due process argument regarding supersedeas by Petitioners and their *amici*, in our view, wrongly states that the decision below is destructive of legitimate utilization review or effective control of workers' compensation medical costs in Pennsylvania and elsewhere. Petitioners have not shown how the challenged method of supersedeas contributed to accuracy of payments—only to blind cost cutting. *Amicus* Federation believes that a review of state cases throws light on both the due process questions before this Court and the suggestion that basic due process requirements are in serious conflict with effective medical cost control in workers' compensation.[13]

The decision of the Court of Appeals in this case is not contrary to the approach of those state courts that have reached similar due process issues. The majority of state court decisions that have confronted the question of suspensions or terminations of workers' compensation benefits have concluded that due process (or the language of their state statutes) requires prior notice to the affected worker and an opportunity to be heard on the proposed termination.[14]

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[13] In addition to utilization review, states have employed a variety of medical cost control mechanisms to workers' compensation programs in recent years, including restrictions upon workers' choice of medical provider or limits on changing providers, mandated managed care, adoption of medical fee schedules, regulation of hospital charges, and medical bill reviews. S. Eccleston and C. Yeager, Workers' Compensation Research Institue, *Managed Care and Medical Cost Containment in Workers' Compensation, A National Inventory, 1997-1998*, xvii-xix.

[14] *See generally* Larson, *Law of Workers' Compensation* (1991) § 81.31(g) at 15-1176 to 15-1183 and Supp. (and cases cited therein).

In *Beckler v. North Dakota Workers Compensation Bureau*, 418 N.W.2d 770 (N.D. 1988), the North Dakota Supreme Court, applying, the *Mathews v. Eldridge* [15] balancing test, held that the continuing right to workers' compensation disability benefits was a protected property right and that due process required prior notice, a summary of the medical evidence, and an opportunity to respond before termination of these benefits. 418 N.W.2d at 772-775. *Accord, Frohlich v. North Dakota Workers Compensation Bureau*, 556 N.W.2d 297, 301-302 (N.D. 1996) (citing *Beckler* and state statutory requirements codifying *Beckler*).

The Supreme Courts of West Virginia and Iowa have agreed with the approach in *Beckler*. *Mitchell v. State Workmen's Compensation Comm'r*, 163 W.Va. 107, 256 S.E.2d 1 at 4 (1979) (Syllabus Pt. 3) (termination of temporary total disability award requires advance notice and an opportunity to supply information, unless the claimant returns to work): *see also Allen v. Workers' Compensation Comm'r*, 173 W.Va. 238, 314 S.E.2d 401 (1984); *Auxier v. Woodward State Hospital-School*, 266 N.W.2d 139, 142-143 (Iowa, 1978), *cert. den.*, 439 U.S. 930 (1978) (state and federal due process requires pretermination notice and opportunity to protest and present proof). *See also Carr v. SAIF Corp.*, 65 Or. App. 110, 670 P.2d 1037, 1046 (1983) (In Banc), *pet. rev. dismissed*, 297 Or. 83, 679 P.2d 1368 (1984) (same).

The Maine Supreme Court declined to require pretermination hearings of voluntary initial payments made under its workers' compensation act (so-called "pay without prejudice" payments), but noted that, once benefits were formally awarded, the Maine act required continuation of benefits until a full hearing and completion of any appeal. *Valliere v. Workers' Compensation Board*, 669 A.2d 1328, 1330 n.2 (Me. 1996), *cert. den.*, —— U.S. ——, 117 S.Ct. 95, 136 L.Ed.2d 50 (1996). *See also*,

[15] 424 U.S. 319 (1976).

Higgins v. Wyoming Worker's Compensation Division, 739 P.2d 129 (Wyo. 1987), *cert. den.*, 484 U.S. 988 (1987) (holding that temporary total disability benefits could be stopped once physician stops monthly certifications of disability assuming that prompt post-termination hearing is provided). Decisions from Rhode Island and Missouri indicate that statutes in these states prevent unilateral discontinuances of workers' compensation payments as well. *Lavey v. Thomas Olean & Sons*, 502 A.2d 344, 346 (R.I. 1985); *P.M. v. Metromedia Steakhouses*, 931 S.W.2d 846, 847-848 (Mo. App. 1996).

Like the Court of Appeals in this case, these state courts have conducted assessments of the due process requirements that obtain for their particular workers' compensation laws in light of this Court's due process decisions. Like the Court of Appeals, they have concluded, in most circumstances, that the *Mathews v. Eldridge* balancing test requires prior notice and an opportunity to be heard. On the record before this Court, *Amicus* Federation agrees with the Court of Appeals that, under Pennsylavnia's workers' compensation system, basic due process requires prior notice and an opportunity to be heard before disabled workers' medical benefits can be suspended indefinitely through the invocation of supersedeas.

Workers' compensation was one of our nation's earliest social insurance programs. For this reason, workers' compensation statutes were adopted initially without regard for modern concepts of due process. As the National Commission on State Workmen's Compensation Laws wrote in 1972, "The basic principles of the present [workers' compensation] program are largely those established 50 or 60 years ago; they can be completely understood only in the context of forces present at their creation." *Report of the National Commission on State Workmen's Compensation Laws* (1972) at 35. To the extent that state courts have faced challenges to those earlier state practices in the light of current due process stand-

ards, the majority have concluded that their state's practices fall short. Petitioners' argument that its summary of state practices with respect to suspensions of benefits in other states should be persuasive authority for this Court's application of due process to Pennsylvania's supersedeas law falls short as well.[16]

In short, generalizations about the impact of the Court of Appeal's decision on other states' workers' compensation programs are, at best, difficult to assess. Nevertheless, it is clear that Pennsylvania's workers' compensation law provides injured workers with a constitutionally protected property interest in their medical benefits that cannot be terminated or suspended without prior notice and an opportunity to be heard. For this reason, the decision below holding invalid on due process grounds the use of supersedeas to stop injured workers' medical benefits should be affirmed.

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16 Petitioners' argue, for example, that state practices regarding the payment of disputed medical bills parallel Pennsylvania's supersedeas' practice. Petitioners' Brief at 48. The Workers' Compensation Research Institute's most recent national inventory, upon which petitioners rely, states that in Pennsylvania "the payer must pay the entire bill while awaiting resolution of the dispute." S. Eccleston and C. Yeager, Workers' Compensation Research Insitute, *Managed Care and Medical Cost Containment in Workers' Compensation, A National Inventory, 1997-1998*, 16. At a minimum, this proves our point that generalizations about state practices are a problematic basis for this Court to use to decide what process is due for workers in Pennsylvania.

CONCLUSION

The judgment of the court of appeals should be affirmed.

Respectfully submitted,

RODERICK M. HILLS, JR.
Assistant Professor of Law
THE UNIVERSITY OF MICHIGAN
LAW SCHOOL
625 South State Street
Ann Arbor, Michigan 48109-1215
(734) 763-9635

RICHARD W. MCHUGH
Counsel of Record
MICHIGAN POVERTY LAW
PROGRAM-WEST
611 Church Street, Suite 4D
Ann Arbor, Michigan 48104-3000
(734) 332-1015
Counsel for Amicus Curiae

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IN THE
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OCTOBER TERM, 1998

AMERICAN MANUFACTURERS MUTUAL INSURANCE COMPANY, *et al.*,
Petitioners,

v.

DELORES SCOTT SULLIVAN, *et al.*,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Third Circuit

BRIEF *AMICI CURIAE* OF THE AMERICAN ASSOCIATION OF RETIRED PERSONS, THE CENTER FOR MEDICARE ADVOCACY, INC., THE NATIONAL CENTER FOR YOUTH LAW, THE NATIONAL HEALTH LAW PROGRAM, THE NATIONAL SENIOR CITIZENS LAW CENTER, AND THE NATIONAL PARTNERSHIP FOR WOMEN & FAMILIES IN SUPPORT OF RESPONDENTS

SALLY HART
CENTER FOR MEDICARE ADVOCACY, INC.
1730 EAST RIVER ROAD
SUITE 107
TUCSON, AZ 85718
(520) 577-1611

COUNSEL FOR *AMICUS CURIAE*
CENTER FOR MEDICARE ADVOCACY, INC.

GILL DEFORD
(COUNSEL OF RECORD)
SARAH LENZ LOCK
AARP FOUNDATION LITIGATION
MICHAEL SCHUSTER
AMERICAN ASSOCIATION OF RETIRED PERSONS
601 E STREET, NW
WASHINGTON, D.C. 20049
(202) 434-2060

COUNSEL FOR *AMICUS CURIAE*
AMERICAN ASSOCIATION OF RETIRED PERSONS

[Additional Counsel Are Listed on Inside Cover]

BEST AVAILABLE COPY

JEANNE FINBERG
NATIONAL CENTER FOR YOUTH LAW
114 SANSOME STREET, SUITE 900
SAN FRANCISCO, CA 91401
(415) 543-3307

COUNSEL FOR *AMICUS CURIAE*
NATIONAL CENTER FOR YOUTH LAW

JANE PERKINS
NATIONAL HEALTH LAW PROGRAM
211 NORTH COLUMBIA STREET
CHAPEL HILL, NC 27514
(919) 968-6308

COUNSEL FOR *AMICUS CURIAE*
NATIONAL HEALTH LAW PROGRAM

VICKI GOTTLICH
NATIONAL SENIOR CITIZENS LAW CENTER
1101 14TH STREET, N.W., SUITE 400
WASHINGTON, D.C. 20005
(202) 289-6976

COUNSEL FOR *AMICUS CURIAE*
NATIONAL SENIOR CITIZENS LAW CENTER

JUDITH L. LICHTMAN
NATIONAL PARTNERSHIP FOR WOMEN & FAMILIES
1875 CONNECTICUT AVENUE, N.W., SUITE 710
WASHINGTON, D.C. 20009
(202) 986-2600

COUNSEL FOR *AMICUS CURIAE*
NATIONAL PARTNERSHIP FOR WOMEN & FAMILIES

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IN THE
SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1998

No. 97-2000

AMERICAN MANUFACTURERS MUTUAL INSURANCE COMPANY, *et al.*,
Petitioners,
v.

DELORES SCOTT SULLIVAN, *et al.*,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Third Circuit

BRIEF *AMICI CURIAE* OF THE AMERICAN ASSOCIATION OF RETIRED PERSONS, THE CENTER FOR MEDICARE ADVOCACY, INC., THE NATIONAL CENTER FOR YOUTH LAW, THE NATIONAL HEALTH LAW PROGRAM, THE NATIONAL SENIOR CITIZENS LAW CENTER, AND THE NATIONAL PARTNERSHIP FOR WOMEN & FAMILIES IN SUPPORT OF RESPONDENTS

INTEREST OF *AMICI CURIAE*[1]

Six national organizations join in this brief, which focuses solely on the first question before the Court, whether the petitioning insurance companies are state actors and therefore required to provide basic procedural protections guaranteed by the due process clause of the Fourteenth Amendment. As the

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[1] No counsel for any party authored any portion of this brief. No persons other than the *amici curiae*, their members, or their counsel made a monetary contribution to the preparation and submission of this brief.

following descriptions of those organizations demonstrate, they, their members, and their constituencies have a significant interest in the outcome of this case and in upholding the Third Circuit's determination that the insurance companies' activities amounted to state action pursuant to prior decisions of this Court. See *Sullivan v. Barnett*, 139 F.3d 158 (3d Cir.), *cert. granted sub nom. American Manufacturers Mutual Ins. Co. v. Sullivan*, 119 S. Ct. 128 (1998).

The American Association of Retired Persons (AARP), a nonprofit membership organization of more than 32 million Americans age 50 or older, is dedicated to addressing the needs and interests of older people. Through education, advocacy, and service, and by promoting independence, dignity, and purpose, AARP seeks to enhance the quality of life for all citizens. In the effort to promote independence, AARP works to foster the health and economic security of individuals as they age by attempting to ensure the availability of quality and economical health coverage.

The Center for Medicare Advocacy, Inc., which is staffed by attorneys, paralegals, a nurse, and technical assistants, provides legal advice, self-help materials, and representation to the elderly and disabled who are unfairly denied Medicare coverage. The Center's work includes responding to over 8,000 telephone calls annually, producing educational materials, pursuing Medicare coverage for beneficiaries who are eligible for both Medicare and Medicaid, and engaging in litigation of national importance. Furthermore, the Center annually represents hundreds of individuals in appeals of Medicare denials, particularly for home health care, and its staff members act as consultants and trainers for groups which are interested in learning about Medicare coverage and appeals or in developing Medicare advocacy projects.

The National Center for Youth Law (NCYL) is a nonprofit corporation which represents the interests of poor children and adolescents in civil litigation. It also assists attorneys nationwide in representing their indigent clients, and is the primary national resource on children's issues to more than 6,000 legal services attorneys and paralegals who request advice, written materials, trainings, mentoring, and co-counseling. NCYL's clients are regular beneficiaries of government-sponsored health care programs, such as Medicaid, and NCYL frequently acts to enforce the rights of children and adolescents in these programs under state or federal law.

The National Health Law Program (NHeLP) is a national public interest law firm that seeks to improve health care for America's working and unemployed poor, minorities, children, elderly, and people with disabilities. NHeLP serves legal services programs, protection and advocacy offices, community-based organizations, the private bar, providers, and individuals who work to maintain a health care safety net for millions of low income people. NHeLP monitors Medicaid, Medicare, and other publicly-funded health care programs, seeks remedies when laws and policies are ignored, and helps Americans to receive needed medical care.

The National Senior Citizens Law Center (NSCLC) is a nonprofit organization that advocates on behalf of elderly poor people. Since its formation in 1972, NSCLC has engaged in litigation, legislative and administrative advocacy, technical assistance, and training in many areas of elder law, including Medicare and Medicaid. NSCLC has brought numerous law suits on behalf of Medicare beneficiaries and Medicaid recipients to protect their rights under these federal statutes and their implementing regulations, and under the Constitution.

The National Partnership for Women & Families (National Partnership) is a national advocacy organization that develops and promotes policies to help women achieve equal opportunity and obtain quality health care and economic security for themselves and their families. Founded in 1971 as the Women's Legal Defense Fund, the National Partnership works to improve access to quality health care through research and analysis, public education, advocacy, and litigation of significant cases. The National Partnership is a leading voice in the effort to ensure that women and families receive quality health care through their health insurance plans, including managed health care plans.

Each of the *amici* organizations thus advocates on behalf of individuals throughout the country, seeking especially to ensure access to health care and to protect and enhance their rights to obtain quality health care. For instance, AARP filed a brief *amicus curiae* last Term in support of the ultimately victorious petitioners in *Geissal v. Moore Medical Corp.*, 118 S. Ct. 1869 (1998). Similarly, attorneys for the Center for Medicare Advocacy represent a nationwide class of plaintiffs in a successful due process challenge which raises the issue of state action in a Medicare context, with AARP filing a supporting *amicus* brief in the Court of Appeals. See *Grijalva v. Shalala*, 152 F.3d 1115 (9th Cir. 1998). And, the Center for Medicare Advocacy, NSCLC, and AARP are co-counsel for a nationwide class of Medicare beneficiaries seeking to enforce procedural protections for recipients of home health care. *Healey v. Shalala*, No. 398CV00418DJS (D.Conn. filed March 4, 1998).

The instant case is of particular concern to the *amici* organizations because of its potentially broad and significant impact on their members and constituencies. The state action issue is obviously of great importance in the context of

workers' compensation programs, and the decision's effect on that aspect alone of the nation's health care system would warrant attention. More broadly, however, this Court's resolution may affect the rights to and surrounding health care in numerous other situations, as petitioners themselves recognize, see Reply Brief for Petitioners on Petition for Writ of Certiorari, at 5 & n.2, and as the courts have begun to address.[2/] As the relationships between state and federal governments on the one hand, and private companies involved in the health care industry on the other, are encouraged and grow, the administration of the nation's health care system is increasingly becoming a joint venture, with dramatic ramifications for the rights of those dependent on that system.

Historically, the two most important public health care programs, Medicare and Medicaid, have involved private entities to some degree. Medicaid, a welfare program administered by each state subject to federal statutory and regulatory requirements, see, *e.g., Atkins v. Rivera*, 477 U.S. 154, 156-157 (1986), pays private individuals and institutions to provide the actual health care. Medicare, a federal insurance program, not only relies on private providers but also utilizes insurance companies to administer the program and distribute payments. See, *e.g., Bodimetric Health Services, Inc. v. Aetna Life & Casualty*, 903 F.2d 480, 482 n.3 (7th Cir. 1990). As managed care models become increasingly more prevalent in

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[2/] For instance, state action holdings have played crucial roles in enforcing procedural rights of beneficiaries of state Medicaid programs. See, *e.g., Catanzano v. Dowling*, 60 F.3d 113, 117-120 (2d Cir. 1995); *Perry v. Chen*, 985 F. Supp. 1197, 1201-1202 (D. Ariz. 1996). Similarly, the right to effective notices and timely hearings for Medicare beneficiaries enrolled in HMOs has largely hinged on the state action question. *Grijalva*, 152 F.3d at 1119-1121.

these public programs, however, the extent and context of the private sector participation is dramatically changing.

The line between providers and insurance companies is becoming less distinct, and decisions regarding the appropriateness of particular health care are being made before, not after, that care is provided. Under the traditional fee-for-service system, doctors provided the care and the question of reimbursement came later; under managed care, where payment is typically on a "capitated" basis (with the plan receiving a set monthly amount per enrollee regardless of usage), there are strong economic incentives for a private plan to question a suggested course of treatment. See, *e.g., Herdrich v. Pegram,* 154 F.3d 362, 375 (7th Cir. 1998). This evolving new role for the private entities involved in publicly funded and authorized health programs renders their decision-making processes more important than ever.

This increasing "privatization" of benefit programs is moving forward rapidly. As of June 1997, more than 15 million Medicaid beneficiaries -- almost 48% of the Medicaid population -- were enrolled in managed care plans, a dramatic increase from the 2.7 million who had been enrolled just six years earlier. Health Care Financing Administration, *National Summary of Medicaid Managed Care Programs and Enrollment* at 1 (Data as of June 30, 1997) <http://www.hcfa.gov/medicaid/trends97.htm>. And, since 1988, the annual increase in Medicare beneficiaries enrolled in risk-based HMOs has been as high as 36%, and in 1998 is still over 20%, "far surpassing the annual growth in the beneficiary population," which has stayed well below 5%. Medicare Payment Advisory Commission, *Health Care Spending and the Medicare Program: A Data Book*, at 30 (July 1998). Nationwide, more than 50,000 Medicare beneficiaries enroll in these plans every month, *id.,* with over six million presently

enrolled. Health Care Financing Administration, *Medicare Managed Care Contract Report* at 1 (Data as of Nov.1,1998) <http://www.hcfa.gov/stats/mmcc1198.txt>.

Of no less importance than this past growth is that January 1, 1999 marks the beginning date of the Medicare+Choice program, Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4001, 111 Stat. 251, 275 (1997), which is intended to change the very nature of the Medicare program: "Alternatives available to beneficiaries under the M+C program include both the traditional managed care plans (such as HMOs) that have participated in Medicare on a capitated payment basis ... as well as a broader range of plans comparable to those now available through private insurance ...." 63 Fed. Reg. 34968 (June 26, 1998). In short, spurred by Congressional action, the Medicare program is aggressively encouraging increased beneficiary participation in private managed care structures.[y] This will increasingly place private entities into relationships with beneficiaries that previously had been the province of government agencies or their agents, which, of course, are subject to constitutional restraints.

The evolution in the administration of government benefit programs thus renders the state action determination important to a rapidly expanding number of individuals. Whether in the context of workers' compensation, Medicaid, Medicare, or any of a host of other programs devised and administered by state and federal governments to secure economic and health security for vulnerable populations, the active participation of private

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[y] It is also anticipated that there will be significant growth in managed care enrollment of Medicaid beneficiaries, as states are now permitted to require their participation in managed care plans without obtaining a waiver from the federal government. Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4701(a), 111 Stat. 251, 489 (1997).

entities has become a critical component, but that development should not occasion a deprivation of individual rights. Judge Wiggins observed for the Ninth Circuit that "the government cannot avoid the due process requirements of the Constitution merely by delegating its duty to determine Medicare coverage to private entities," *Grijalva*, 152 F.3d at 1121, and, on behalf of their members and constituencies, the *amici* organizations are anxious to see that position upheld in the overall context of the state action inquiry.[4/]

SUMMARY OF ARGUMENT

Although the theory of state action is a difficult concept and its evolution has engendered considerable debate, this Court has developed and consistently employed a two-step process. *Lugar v. Edmondson Oil Co.*, 457 U.S. 922, 937 (1982). As Justice White explained for the Court in that decision, the first step requires a determination of whether the state has authorized the conduct at issue, and the second looks to the additional factors which would convert private action into state action. The three principles necessary to make this second determination, by evaluating the totality of the circumstances, were explicitly outlined in *Edmonson v. Leesville Concrete Co., Inc.*, 500 U.S. 614 (1991) and reiterated in *Georgia v. McCollum*, 505 U.S. 42 (1992). These decisions have not been overruled, and the court below relied on and applied their principles in making its decision.

Since suspension of medical coverage was here authorized by the statute, there is no doubt that the first *Lugar* step is met. In considering the first of *Edmonson*'s three principles relevant

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[4/] The blanket written consents of the parties to the filing of *amicus curiae* briefs has been filed with the Clerk of the Court pursuant to Supreme Court Rule 37.3.

to the second step, the Third Circuit correctly noted the insurance companies' significant reliance on governmental assistance in effecting the suspensions. The state is involved in every facet of the dispute resolution process, and it could not be accomplished without the state's consistent involvement. The court below also noted that suspension of benefits pending dispute resolution is a traditional governmental function in benefit programs. Third, the state aggravates the harm by locking injured workers into a system which was intended to provide a balance between the needs and rights of all parties but which instead gives the insurers a significant advantage by allowing unilateral suspension of health coverage with the support and approval of the state. Especially when viewed together, these factors conclusively demonstrate that the insurance companies are state actors.

ARGUMENT

THE COURT BELOW CORRECTLY APPLIED THE PRINCIPLES WHICH HAVE BEEN ESTABLISHED BY THIS COURT AND FORMULATED INTO A CLEARLY STATED FRAMEWORK.

A. This Court should apply the state action test which it has developed over time and which it has now definitively delineated.

1. It has become a truism that the state action inquiry is a difficult one, which "frequently admits of no easy answer." *Jackson v. Metropolitan Edison Co.*, 419 U.S. 345, 350 (1974). The court below termed it "one of the most troublesome issues of constitutional law," *Sullivan*, 139 F.3d at 167, and this Court recently acknowledged again the "difficult terrain". *Lebron v. National R.R. Passenger Corp.*, 513 U.S. 374, 378 (1995).

Not surprisingly, the commentators have been anxious to propose their solutions to the apparent dilemma,[3/] appearing almost gleeful in their criticism. One 1991 analysis stated that "nearly every article about the state action doctrine published in the last twenty years quotes and concurs with Professor Charles Black's characterization of the doctrine as 'a conceptual disaster area,'" Henry C. Strickland, *The State Action Doctrine and the Rehnquist Court*, 18 HASTINGS CONST. L.Q. 587, 588 (1991) (citation omitted), while another contends that the doctrine "remains a dark thicket of constitutional law." Ronald J. Krotoszynski, Jr., *Back to the Briarpatch: An Argument in Favor of Constitutional Meta-analysis in State Action Determinations*, 94 MICH. L. REV. 302, 303 (1995)[hereinafter, *Constitutional Meta-Analysis*].

The difficulty of devising a state action standard, however, should not lead to despair that such a task is impossible -- or that, as one of the *amicus* briefs supporting petitioners expressly requests, the Court simply replace the existing standard. See Br. *Amicus Curiae* on Behalf of the National Ass'n of Waterfront Employers, *et al.*, at 15-17 (urging "two clarifications"). Indeed, the irony of attacking the Court's efforts to develop a fair and effective analytical tool is that the Court has already done exactly that. While there undoubtedly have been fits and starts in the process, and, as the Court itself has noted, its decisions in the area "have not been a model of consistency," *Lebron*, 513 U.S. at 378 (quoting *Edmonson v. Leesville Concrete Co., Inc.*, 500 U.S. 614, 632 (1991) (O'Connor, J., dissenting)), the Court, after analyzing state action in a wide variety of legal and factual circumstances, has

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[3/] *See, e.g.*, Barbara Rook Snyder, *Private Motivation, State Action and the Allocation of Responsibility for Fourteenth Amendment Violations*, 75 CORNELL L. REV. 1053 (1990); Erwin Chemerinsky, *Rethinking State Action*, 80 NW. U. L. REV. 503 (1985).

arranged those considerations into a viable conceptual framework. While some factors were originally evaluated independent of an integrated test, the Court has now described and applied a mechanism which both observes past precedent and provides appropriate guideposts for future guidance.

2. The first step to effect this organizational arrangement took place in 1982, when the Court summarized its previous holdings as "insist[ing] that the conduct allegedly causing the deprivation of a federal right be fairly attributable to the State." *Lugar v. Edmondson Oil Co.*, 457 U.S. 922, 937 (1982). To establish this "fair attribution", the Court divined, from prior cases, two necessary components or principles:

> First, the deprivation must be caused by the exercise of some right or privilege created by the State or by a rule of conduct imposed by the State or by a person for whom the State is responsible .... Second, the party charged with the deprivation must be a person who may fairly be said to be a state actor.

Id.

Although this clear-cut statement and summary of the law remains the standard for determining state action, petitioners are determined to undercut its effective application. In a transparent attempt to secure a rule which is less likely to bind them to the inconvenient standards applicable to the government, petitioners and their supporting *amici* are ready and willing to decry the state of state action law and to request that the Court "bring order to this cacophony." Petition for Writ of Certiorari (Pet. Writ Cert.) at 22. They begin this attack by dismissing the first component of the *Lugar* test as essentially meaningless, describing it as relevant only when the

private entity violates the law. Brief for Petitioners (Br. Pet'r) at 14.

Justice White, the author of *Lugar*, explained the broader sweep of that component by comparing two prior decisions. In one, *Moose Lodge No. 107 v. Irvis*, 407 U.S. 163 (1972), the Court had reached its conclusion of no state action by "focus[ing] primarily on the question of whether the admittedly discriminatory policy could in any way be ascribed to a governmental decision." *Lugar*, 457 U.S. at 937-938. By contrast, in the second, *Flagg Bros., Inc. v. Brooks*, 436 U.S. 149 (1978), since "the State was responsible for the statute" at issue, the analysis was directed at "the other component of the state-action principle." *Lugar*, 457 U.S. at 938.[6] While illegal action by the private entity may place its behavior outside the realm of state action, that is only part of the equation: *any* conduct carried out without the authorization of the state has the same effect and cannot be state action. In short, *Lugar*'s first component allows a holding of state action only when the state has sanctioned a private entity to undertake the allegedly impermissible conduct. See also, *e.g., Edmonson v. Leesville Concrete Co., Inc.*, 500 U.S. 614, 620-621 (1991).

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[6] Justice White added further explanation through his concurrences to two other state action cases decided on the same day as *Lugar*. In both, he agreed that there was no state action because the activity at issue was not based on conduct or policy of the state. See *Rendell-Baker v. Kohn*, 457 U.S. 830, 843-844 (1982) (White, J., concurring in the judgment); *Blum v. Yaretsky*, 457 U.S. 991, 1012 (1982) (White, J., concurring in the judgment). And, as Justice White added, this was, for all practical purposes, the crucial factor in the majority's *Blum* analysis: "This is the clear import of the majority's conclusion that the 'decisions ultimately turn on medical judgments made by private parties according to professional standards that are not established by the state ....'" *Id.* (citation omitted).

The second *Lugar* principle elicits equal disdain from petitioners; it is, they say, "with all due respect, ... tautological." Pet. Writ Cert. at 21. But Justice White's opinion speaks directly to the several concerns which had motivated the Court through the years of state action analysis. He focused on the fact that, once the state's involvement had been established through a rule or policy (the first component), the next step was to determine whether there existed "'something more' which would convert the private party into a state actor ...." *Lugar,* 457 U.S. at 939. To make this determination requires the practical and realistic recognition that state action may exist in a variety of circumstances, and that, to respond to these variations, the Court has "articulated a number of different factors or tests in different contexts." *Id.* Although the Court has attached various labels to the several "tests" which it has employed and the commentators have attempted to further refine them or suggested other terminology to describe them,[7] the bottom line of this second component is the recognition first stated in 1961: "'Only by sifting facts and weighing circumstances can the nonobvious involvement of the State in private conduct be attributed its true significance.'" *Id.* at 939 (quoting *Burton v. Wilmington Parking Auth.*, 365 U.S. 715, 722 (1961)). The precise nature of these tests -- whether they "are actually different in operation or simply different ways of characterizing the necessarily fact-bound inquiry that confronts the Court in such a situation" -- need not be resolved. *Lugar*, 457 U.S. at 939. The second component therefore incorporates the considerations which imbue the actions of a private party with the state's mantle.

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[7] See, *e.g.*, G. Sidney Buchanan, *A Conceptual History of the State Action Doctrine: The Search for Governmental Responsibility (I)*, 34 HOUS. L. REV. 333, 345-351 (1997); *Constitutional Meta-Analysis*, *supra*, at 318-320.

3. Nine years later, in *Edmonson*, a case which petitioners mention only in passing (see Br. Pet'r at 14, 18, 24) and with studied indifference to its significance and relevance, the Court took the next step in summarizing and setting out the guiding principles for state action analysis. Applying "the framework for state-action analysis set forth in *Lugar*," the Court concluded that the first component was met, as the right to peremptory challenges clearly derived from state authority. *Edmonson*, 500 U.S. at 620-621.

The Court then described the critical inquiry relating to the second component:

> [O]ur cases disclose certain principles of general application. Our precedents establish that ... it is relevant to examine the following: the extent to which the actor relies on governmental assistance and benefits ...; whether the actor is performing a traditional governmental function ...; and whether the injury caused is aggravated in a unique way by the incidents of governmental authority ....

Id. at 621-622 (citations omitted). Applying "these three principles to the circumstances" of the case, a court may then determine whether the second aspect of the *Lugar* framework is satisfied. *Id.* at 622.

The *Edmonson* Court reviewed the three principles in turn, relying on prior decisions to provide the supporting analysis. In so doing, the Court indicated that no one factor is determinative, that they are not discrete or distinct tests which require complete satisfaction in order for state action to exist; rather, "the principles of general application" should be looked at in each instance to determine whether, in light of the totality of those circumstances, the private entity may be deemed a

government actor. As Judge Greenberg of the Third Circuit has summarized:

> Rather than stating a series of discrete tests and applying them separately to determine whether each by itself is satisfied, the Court considered a number of factors, and weighed them to determine whether, all things considered, the otherwise private actor fairly could be deemed to be a state actor. Under that new framework, courts should consider the principles furthered by the previous tests as part of a single balancing and weighing approach. And it should apply to all cases involving the question of whether a private actor is engaged in state action.

Mark v. Borough of Hatboro, 51 F.3d 1137, 1156 (3d Cir. 1995) (Greenberg, J., concurring); see also *Grijalva*, 152 F.3d at 1120; accord, *Constitutional Meta-Analysis*, *supra*, at 337-345; G. Sidney Buchanan, *A Conceptual History of the State Action Doctrine: The Search for Governmental Responsibility (II)*, 34 HOUS. L. REV. 665, 756-764 (1997).

The actual application of the three principles summarized in *Edmonson* requires careful analysis of each situation's circumstances in light of this Court's prior decisions. That separate inquiry forms the next part of this brief, but the *amici* wish to emphasize that the *framework* for the state action inquiry has been conclusively established through *Lugar* and *Edmonson*. And that analytical approach was expressly reaffirmed in *Georgia v. McCollum*, 505 U.S. 42, 50-51 (1992).

Although neither the court below nor the Ninth Circuit in *Grijalva* referred to the *Lugar-Edmonson* model, by implication and explicit analysis both courts considered and applied the principles which this Court imported from previous decisions to define that framework. See *Grijalva*, 152 F.3d at 1119-

1120; *Sullivan*, 139 F.3d at 168-169. The petitioners' strident accusations -- that the Third Circuit "essentially threw up its hands, justifying its conclusion ... by reference to a congeries of seemingly unrelated factors", Pet. Writ Cert. at 22, and, instead of providing an "analytical structure", *id.*, "offered a vague set of truths, half-truths, and irrelevancies," Br. Pet'r at 14, and, further, "did not think it necessary to offer a coherent theory," *id.* at 15 -- misapprehends that court's reliance on the analyses which this Court has condoned. The court below merely failed to specify the precise contours of the tests and their place within the overall framework. In its substance, however, the analysis was entirely consistent with this Court's pronouncements, and no good reason exists to alter the roadmap which now provides clear directions.

B. The Third Circuit's analysis and conclusion rely on the principles and their application which the *Edmonson* Court gleaned from this Court's prior decisions.

1. In this case, there can be no dispute that the first step of the *Lugar* test -- that the deprivation at issue be caused "by the exercise of some right or privilege created by the State," 457 U.S. at 936 -- is met. Here, the denial of due process is authorized by the utilization review procedures and supersedeas mechanism in Pennsylvania Workers' Compensation Act, 77 Pa.Stat.Ann. § 531(5) and (6), and its implementing regulations. 34 Pa.Code § 127.208(e). A statute authorizing the action which forms the basis for the deprivation represents the paradigm for satisfaction of this first element. See, *e.g.*, *McCollum*, 505 U.S. at 51; *Edmonson*, 500 U.S. at 621. In all likelihood, because this step was so obviously met, the court

below saw no reason to state the point explicitly.[V] Indeed, on several occasions after the *Lugar* standard was announced, this Court itself neglected to mention specifically this first part of the test, see, *e.g.*, *Tulsa Professional Collection Services, Inc. v. Pope*, 485 U.S. 478, 485-486 (1988), but that failing does not imply that a court is operating without an "analytical structure".

2. In discussing the second part of the *Lugar* test, the Third Circuit did not announce that it was considering the three principles. But, again, the failure to do so does not condemn the analysis as inherently faulty, especially where, as here, the court demonstrated its awareness of the issues surrounding the state action inquiry -- the difficulty of application, the dependence "upon the factual contexts in which the controversies arise," and the use of variously worded standards and the problems thereby occasioned. *Sullivan*, 139 F.3d at 167.

First, the Third Circuit carefully examined the extent to which the insurance companies' actions in stopping payments relied on governmental assistance; it made clear that this was one of the relevant principles informing its conclusion that the insurers were state actors:

> The insurers have no power to deprive or terminate such benefits without the permission and participation of the Commonwealth .... [T]he Commonwealth is intimately involved in any decision by an insurer to terminate an employee's constitutionally protected benefits because an

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[V] The Ninth Circuit also failed to mention this aspect of the *Lugar* test, see *Grijalva*, 152 F.3d at 1119, and probably for the same reason. Since the HMOs were operating under the authority of the federal statutes and rules governing Medicare and pursuant to contract with the federal government, *id.* at 1117-1119, there could be no doubt on this point.

> insurer cannot suspend medical payments without first obtaining authorization from the Bureau. However this authorization may be characterized, any deprivation that occurs is predicated upon the State's involvement.

Id. at 168. Just as the private litigants in *Edmonson* were unable to exercise peremptory challenges without invoking the overt, significant assistance of the court, so too are the insurers unable to halt medical benefit payments without employing the power and assistance of state officials. The Pennsylvania statute specifies that an insurer may only be relieved of its obligation to pay for health coverage by following the utilization review procedures, which mandate significant state involvement. 77 Pa. Stat.Ann. § 531(5).

The state creates the system of utilization review ("UR") and must authorize and certify the organizations ("UROs") which will perform the reviews. 77 Pa.Stat.Ann. § 531(6)(i); 34 Pa. Code §§ 127.650-.670. The state mandates what kind of provider may perform the review, what the review process should be, how long it may take, and what information the URO may examine to reach its conclusion. 77 Pa. Stat.Ann. § 531(6)(ii); 34 Pa. Code §§ 127.461-.476. The state's implementing regulations provide that the insurance company's obligation to make payment within thirty days "may be tolled only if review . . . of the treatment is requested during the 30-day period under the UR provisions." 34 Pa. Code § 127.208(e).

Furthermore, the insurer's "request" for the UR is filed with the state on a state prescribed form, 34 Pa. Code § 127.452(a) and (c), which asks *the state* to invoke the statutorily created procedures of UR. 34 Pa. Code

§ 127.452(a).[2/] The state requires the insurer to certify that it served its request for UR on all parties, including the employee, but, significantly, does not require the insurer to provide notice that, once the state accepts the request, the insurer may terminate the injured employee's medical benefits during the review or for an even longer period of time, perhaps permanently. See 34 Pa. Code §§ 127.208 (e) - (g), 127.452.

If the state determines that the form has been properly completed, the state assigns the request to a URO and sends the Notice of Assignment to the URO, the employee, the employer, the insurer, and the provider. The Notice prominently features its origin: The Commonwealth of Pennsylvania, Department of Labor and Industry, Bureau of Workers' Compensation. J.A. at 6.

At this point, while the state-created URO resolves the dispute, the state may toll the insurer's obligation to pay for health coverage. 34 Pa. Code § 127.208(e). The URO reports to the state and sends a copy to the parties. See 34 Pa. Code §§ 127.472, 127.476. A party may appeal the URO's findings by filing a petition with the state, on yet another state prescribed form. See 77 Pa. Stat.Ann. § 531(6)(iv); 34 Pa. Code § 127.551. The state assigns the appeal to an administrative law judge, who engages in a *de novo* review, 77 Pa. Stat.Ann. § 531(6)(iv); 34 Pa. Code § 127.556, and makes the final determination as to whether the insurer must pay.

[2/] "I hereby request the Bureau of Workers' Compensation assign an authorized utilization review organization to review the reasonableness and necessity of proposed, current or past care of the above employee." "Utilization Review: Initial Request" J.A. at 5.

The state is thus intimately involved in every aspect of the dispute resolution process, from its creation of the utilization review system, to its authorization of the decision making body; from its assignment of the case, to its receipt of the report; from its provisions for notice, to its mechanisms for appeal. The state is overtly providing significant assistance to the insurer in tolling its obligation to pay worker's health benefits pending dispute resolution. As in *McCollum,* 505 U.S. at 52, *Edmonson*, 500 U.S. at 624, and *Tulsa Professional Collection Services, Inc.*, 485 U.S. at 486-487, the actions of the private entity are not self-executing; in those cases, courts were the state enablers, making it possible for the private actors to carry out the challenged activity, while, in this situation, the Bureau of Workers' Compensation plays a critical role in the continuum of activity which may result in the suspension of health coverage. Also, like the parking authority in *Burton*, the state has here created a partnership with the insurers to replace the tort system; this is a working or symbiotic relationship within a comprehensive statutory scheme, so that the state has "so far insinuated itself into a position of interdependence with [the private entity] that it must be recognized as a joint participant in the challenged activity." *Burton*, 365 U.S. at 725.

Second, the court below also recognized that the insurance companies' ability to "invoke the supersedeas, or to stop payments, is a power that traditionally was held in the hands of the State." *Sullivan,* 139 F.3d at 168.[10/] In creating and

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[10/] There has been some dispute about the *Edmonson* Court's elimination of the "exclusivity" element of the governmental function test. See, *e.g., United Auto Workers v. Gaston Festivals, Inc.*, 43 F.3d 902, 906 n.2 (4th Cir. 1995). This Court did take that action, however, and followed it in *McCollum*, 505 U.S. at 52. In light of the *Edmonson* decision to weigh several factors, rather than to require total compliance with one, it was logical to "delete the 'exclusivity' requirement and use the public function (continued...)

administering its worker's compensation system, the state is exercising its traditional police powers of resolving disputes and creating remedies for injuries to its citizens, and this Court has held that protecting the rights of litigants is a "critical governmental function." *Edmonson*, 500 U.S. at 624. In exchange for providing a courtroom forum in which injured workers may seek redress for their injuries, Pennsylvania has created administrative remedies, eliminating the need to prove fault and establishing a statutory obligation to pay medical benefits for the injured worker. Although the state compels the insurer to pay the benefits prior to a determination that the medical treatment is reasonable or necessary, the insurer may dispute that obligation, and, while seeking resolution by the state, may toll further payment. Tolling or suspension of a legal obligation pending dispute resolution is unquestionably a governmental function, one which courts and administrative agencies traditionally perform. See, *e.g., Mathews v. Eldridge*, 424 U.S. 319, 324 (1976) (Social Security Administration suspending disability benefits pending administrative and judicial review). Pennsylvania has thus delegated to insurers the discretion to delay their legal obligations when they invoke utilization review, the state-created forum for dispute resolution.

Third, the state's significant participation in the unilateral suspension of medical benefits prior to resolution of the dispute aggravates the deprivation. The critical feature of Pennsylvania's scheme is the substitution of guaranteed and quick wage and medical benefits for the possibility of obtaining, in the long run, economic damages, damages for pain and suffering, and punitive damages. This is a mandatory

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[10/] (...continued)
concept as part of a broader state action inquiry." *Mark*, 51 F.3d at 1157 n.2 (Greenberg, J., concurring); see also *id.* at 1157-1158.

and exclusive system, with the workers having no option. As the Third Circuit emphasized by comparing the injured workers to the prisoners in *West v. Atkins*, 487 U.S. 42 (1988), "they are locked into the system, and any relief that the employees obtain is strictly through the program which the State has designed." *Sullivan*, 139 F.3d at 169.

The balance of this scheme is greatly skewed, however, by the state's elimination of the right to immediate payment of medical benefits, which occurs when an insurance company invokes the state's procedures to delay or terminate the benefits pending the dispute resolution. And, it is unmistakably the state and its functionaries who ultimately determine whether the worker will receive medical benefits; even the Notice of Assignment for utilization review comes with the state's imprimatur, on Commonwealth letterhead complete with the Commonwealth's seal. It is the state which permits the insurer to cease payment even before the state has made its determination that the treatment was unreasonable -- despite the fact that one of the statute's fundamental premises was the guarantee of health care to injured workers.

Although the forum in which this deprivation takes place, the utilization review process, is administrative, it is as much a creature of the state as were the courts in *Edmonson*. Just as the courthouse in that situation served as the backdrop for, and provided the implicit approval of, racial discrimination, so too does the administrative process created by the state furnish the stage on which the insurers deprive injured workers of medical coverage.

In sum, the insurance companies' actions are intertwined with those of the state, and they can only suspend payments pursuant to that relationship and in reliance on state authority.

Furthermore, taking that action is the typical function of a state agency, as the insurers have been thrust into a role historically played by agencies. Finally, the state has aggravated the harm by locking injured workers into a system that was supposedly a fair replacement for the expense and vagaries of tort law but which instead authorizes unilateral and indefinite suspension of that most cherished of modern rights, health coverage. This situation is not a matter of mere state regulation, which alone is not sufficient to describe state action, see, *e.g.*, *Jackson v. Metropolitan Edison Co.*, 419 U.S. 345, 350 (1974), nor does it depict only a state reaction to an independent private decision made pursuant to professional standards, as in *Blum*, 457 U.S. at 1008-1009. The insurers' actions here are authorized by the state as part of a comprehensive state-created and -run scheme which encompasses all the participants in the drama: the employers, the insurers, the workers, and the state. When viewed in the totality of its circumstances which *Edmonson* demands, this scenario depicts the essence of state action.

CONCLUSION

The judgment of the court of appeals should be affirmed.

Respectfully submitted,

GILL DEFORD
SARAH LENZ LOCK
AARP Foundation Litigation
MICHAEL SCHUSTER
American Association of Retired Persons

SALLY HART
Center for Medicare Advocacy, Inc.

JEANNE FINBERG
National Center for Youth Law

JANE PERKINS
National Health Law Program

VICKI GOTTLICH
National Senior Citizens Law Center

JUDITH L. LICHTMAN
National Partnership for Women &
Families

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No. 97-2000

IN THE

Supreme Court of the United States

OCTOBER TERM, 1998

AMERICAN MANUFACTURERS MUTUAL INSURANCE COMPANY, *et al.*,

Petitioners,

vs.

DELORES SCOTT SULLIVAN, *et al.*,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

BRIEF OF *AMICUS CURIAE* CARL KRESCHOLLEK IN SUPPORT OF RESPONDENTS

DAVID M. LINKER
Counsel of Record
FREEDMAN AND LORRY, P.C.
Attorneys for Amicus Curiae
400 Market Street, Suite 900
Philadelphia, Pennsylvania 19106
(215) 925-8400

150027

Counsel Press LLC
FORMERLY LUTZ APPELLATE SERVICES
(800) 274-3321 • (800) 359-6859

BEST AVAILABLE COPY

QUESTIONS PRESENTED

Under Pennsylvania's Workers' Compensation Act, 77 Pa. Stat. Ann. §§ 531(5) and (6), workers' compensation insurers are permitted to withhold payments to health care providers during a utilization review to determine whether medical treatment was reasonable and necessary. The questions presented are:

I. Whether private companies providing workers' compensation insurance to private employers become "state actors" for purposes of the Due Process Clause when they elect to use a state-authorized utilization review procedure.

II. Whether the Due Process Clause requires workers' compensation insurers to pay disputed medical bills prior to a determination that the medical treatment was reasonable and necessary.

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INTEREST OF *AMICUS CURIAE*

Carl Kreschollek ("Kreschollek") is the plaintiff in an action under 28 U.S.C. § 1331 against the United States. Kreschollek alleges that the United States Department of Labor violated his Fifth Amendment right to due process when his employer and its workers' compensation insurance carrier suspended payments of indemnity compensation benefits paid to him under the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. § 901-950 ("LHWCA") without first affording Mr. Kreschollek prior notice or a hearing. *See, e.g., Kreschollek v. Southern Stevedoring Company, et al.*, No. 93-3903 (D. N.J. September 30, 1997); *Kreschollek v. Southern Stevedoring Company*, 78 F.3d 868 (3rd Cir. 1996). The action is pending in the United States District Court for the District of New Jersey before United States Senior District Judge Joseph H. Rodriguez.

The United States has filed an amicus brief in support of petitioners in this case. The United States contends, in part, that it has an interest in the disposition of this case based on the similarity of issues herein and the issues in *Kreschollek*. *Kreschollek* contends that the arguments that the federal amicus have filed in this case relating to its analysis of the private interest component of this Court's balancing test in *Mathews v. Eldridge*, 424 U.S. 319 (1975) are inconsistent with the contentions presented to the District Court by the federal defendants in the LHWCA claim. Thus, our brief focuses on Issue Two of the Questions Presented.[1]

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1. Pursuant to Supreme Court Rule 37.6, Kreschollek states that no counsel for a party authored this brief in whole or in part: and that no person or entity, other than amicus and its counsel, contributed monetarily to the preparation and submission of this brief. Written general consents to the filing of this and other amicus briefs in this proceeding have been lodged with the Clerk.

SUMMARY OF ARGUMENT

Mr. Kreschollek contends that a litigant in the federal courts – be it a private citizen or the federal government – has the duty to submit consistent positions on alleged similar issues when a party or amicus submits argument to a federal court. The federal amicus analogize the private interest in *Sullivan* in the uninterrupted payment of medical expenses to a commercial insurance dispute between a medical insurance carrier and its insured. The federal amicus further contend that the private interest in *Mathews*, i.e., the suspension of social security disability benefits prior to a pre-termination hearing, is *more* substantial than the private interests of the respondents in *Sullivan*. *See* Federal Amicus Brief at pp. 18, 24 & 28.

We contend that the aforecited analysis is inconsistent with the federal defendants' private interest analysis in *Kreschollek*. There, the federal defendants have argued that Mr. Kreschollek's "private interest" in the uninterrupted receipt of indemnity benefits under the LHWCA is a *less* substantial private interest than the private interest in the uninterrupted receipt of medical treatment. In light of this inconsistency, the federal amicus arguments in this case are without merit.

ARGUMENT

In the seminal case of *Mathews v. Eldridge*, 424 U.S. 319 (1976), this Court announced a three part test for determining whether a party's right to due process had been violated:

> Our prior decisions indicate that identification of the specific dictates of due process generally requires consideration of three distinct factors: First, the private interest that will be affected by the official action; second, the risk of erroneous deprivation of such interest through the procedures used, and the probable value, if any, of additional substitute procedural safeguards; and, finally, the government's interest, including the function involved and the fiscal and administrative burdens that the additional or substitute requirement would entail.

Id. at 335.

The thrust of the federal amicus private interest analysis is that respondents private interest should be accorded less weight than the private interest of the social security disability recipient in *Mathews* since

> the insurer's temporary withholding of payment for a particular treatment does not affect the employee's disability status . . . *Mathews*, by contrast, involved a complete termination of disability benefits.

See Federal Amicus Brief at p. 28.

Ironically, the federal defendants in *Kreschollek* have accepted the Third Circuit's private interest analysis in its brief to Judge Rodriguez in *Kreschollek*. In an extensive discussion of Sullivan's applicability to the private interest issue in *Kreschollek*, the federal defendants argued:

> Application of the principles established in *Mathews v. Eldridge*, thus plainly demonstrate that due process does not entitle a Longshore claimant to a hearing before an ALJ before an employer terminates compensation payments that have been made voluntarily. The question remains whether such payments can be discontinued without prior

notice, which *Kreschollek* alleges also violates his constitutional right to due process (Prayer for Relief ¶2-3). *Kreschollek* may be expected to rely on the recent decision of the Third Circuit in *Sullivan v. Barnett* in support of this argument. In *Sullivan*, the Court reviewed a provision of the Pennsylvania Workers' Compensation Act, 77 Pa. Stat. Ann. §531(5) and (6) (West Supp. 1977) which allows employers or insurance carriers providing medical benefits to claimants receiving benefits under that statute, to request the state Bureau of Workers' Compensation ("the Bureau") to review a specific treatment ("utilization review") received by an employee. If that request is granted by the Bureau, the statute allows the employer/insurer to suspend payment for the medical treatment in question pending review. 139 F.3d at 163-164. Although the employee is given notice that the employer/insurer has filed a request for utilization review, neither the form request nor the notice that the case has been assigned to a group of health care professionals for review indicate that the employee's medical benefits may be terminated during review of the disputed treatment. 139 F.3d at 164. *Sullivan* complained that these "supersedeas" provisions of the Pennsylvania Act violated the procedural due process guarantees under the Fourteenth Amendment because it provides no notice to the employee that the employer/insurer can stop paying for the contested medical treatment pending review. *Id.* at 171. The *Sullivan* plaintiffs also challenged the constitutionality of the supersedeas provision for its failure to provide for an opportunity to be heard prior to the suspension of the medical treatment in question. *Id.* at 174.

On the issue of notice, the Court in *Sullivan*, observed that "the level of notice required before an individual is deprived of a constitutionally protected property interest depends upon the particular benefits at issue." 139 F.3d at 158 (citing *Morrissey v. Brewer*, 408 U.S. 471, 481, 92 S.Ct. 2593, 2600 (1972), "Due process is flexible and calls for such procedural protections as the particular situation demands."). In finding that the Pennsylvania Act provided insufficient notice of suspension of medical treatment, the court in *Sullivan* was particularly influenced by the nature of the benefit at stake – the uninterrupted provision of medical treatment for an injury severe enough to disable the employee for work. 139 F.3d at 158. This interest, the court found, was more akin to the receipt of welfare benefits (*Goldberg v. Kelly*, 397 U.S. 254), and to the uninterrupted flow of utilities (*Memphis Light, Gas & Water Div. v. Craft*, 436 U.S. 1) than it is to the purely pecuniary interest in the uninterrupted flow of disability compensation pending final administrative decision, for which, unlike medical treatment, there are adequate substitutes. *Mathews*, 424 U.S. at 340.

The interests of the recipient of medical treatment, welfare benefits and utilities who may not lose those benefits without the formal process of notice and opportunity to respond, are plainly distinguishable from the purely pecuniary interest of an employee who receives voluntary payments of compensation under the Longshore Act in an informal system that allows, as a form of quid pro quo, an employer to terminate those benefits without notice. In contrasting the situation of an employee

who is denied needed medical treatment pending review with that of an individual who is merely denied the receipt of disputed benefits, the Court stated (139 F.3d at 175);

> Although a monetary award may compensation an individual for financial losses, a monetary award cannot be deemed an adequate, effective, or appropriate substitute for relieving an employee's disability or pain. Nor can it be a substitute for necessary medical care.

These considerations, which the Court termed "a weighty and significant factor in the pre-termination calculus." (Id.) are wholly missing from the instant case. At 34-36 (emphasis supplied).

The flaw in the argument of the federal defendants in *Kreschollek* and the federal amicus in this case is their failure to understand that an injured worker's right to due process prior to the suspension of his medical or indemnity benefits are *both* important private interests. The United States trivializes these interests because it administers the LHWCA or, in some instances, acts as a self-insured under the LHWCA or its extensions. As such, the United States is not acting as a dispassionate friend of the Court in this case. Rather, the United States' views should be given the weight this Court would customarily apply to any special interest group that perceives a financial benefit in the outcome of a case.

CONCLUSION

The United States asserts it is generally interested in the faithful application of state action and due process principles. *See* Federal Amicus Brief at p. 1. We submit that this case constitutes the exception to the general rule.

For the reasons stated by Judge Garth, the Third Circuit's disposition of the questions presented in this case was faithful to this Court's state action and due process analysis and should be affirmed.

Respectfully submitted,

DAVID M. LINKER
Counsel of Record
FREEDMAN AND LORRY, P.C.
Attorneys for Amicus Curiae
400 Market Street, Suite 900
Philadelphia, Pennsylvania 19106
(215) 925-8400